Embracing the Courage to Change

Elliant Counseling Services

Welcome!

Thank you for choosing Elliant Counseling Services, PC (**ECS**). We are dedicated to providing quality counseling services. Below, you will find information regarding our office policies, non-discrimination, confidentiality, consent and competent service.

This packet provides you and your counselor the information necessary to move forward with counseling services.

Please complete and sign the following forms for your initial meeting with your counselor and retain a copy for your personal records.

Thank You!

Elliant Counseling Services, PC

7500 E Arapahoe Road, Suite 295

Centennial, Colorado 80112

720-883-1480 | www.elliantcounseling.com

Practice, Payment and Confidentiality Policies

SESSIONS & FEES

ECS therapists are divided into 3 different levels of experience and so we have 3 different rates.
We charge the following fee/per minute schedule:

Lead Therapist
$155/50 minute session (typical therapy hour)
$230/75 minute session
$335/100 min 2-hour Intensive Session
$490/150 Min 3-hour Intensive Session

Specialist
$130/50 minute session (typical therapy hour)
$195/75 minute session
$275/100 Min 2-hour Intensive Session

Associate
$100/50 minute session (typical therapy hour)
$150/75 minute session
$225/100 Min 2-hour Intensive Session

Initial therapy sessions are 75 minutes long and bills at the 50 min rate. This allows adequate time to go over your welcome packet information, reasons for seeking therapy, and discussing therapeutic goals.

Phone consultations and support calls lasting more than 10 minutes are billed in 15-minute increments. Various groups are available to attend and sessions are $75 per 90-minute group.

PAYMENT POLICY

ECS therapists see clients on a fee-for-service basis only and the client (parent or responsibly party) is responsible for payment in full at the time of each session. Any other arrangements must be made in advance. We accept cash, check, and all major credit/debit/FSA/HSA cards. Any check returned for non-sufficient funds will be charged a $34.00 administrative fee, plus any additional banking fees associated with the check.

INSURANCE

ECS does not directly bill any insurance or medical plan providers. Many insurance plans reimburse for some portion of psychotherapy. Please direct questions about reimbursement amounts and timelines to your insurance company. ECS will provide an insurance-ready Receipt of Services Rendered form for you to initiate the reimbursement process privately through your insurance company if you so choose. Please know that it is your responsibility to pursue these claims. ECS will not complete any insurance paperwork and we are not an in-network provider.

CANCELLATIONS / LATE / NO SHOW

We understand that it may, at times, be necessary to cancel an appointment. To help us be the most efficient and responsible in the use of our time, we require that any changes or cancellations be made a minimum of 24 hours in advance. The best way to communicate with us regarding changes or cancellations is by phone. Without this 24-hour notice, you will be charged a $75.00 fee for that appointment. If you are late for an appointment, we must still end on time and you will be charged for the full session. If you do not call and do not show for a scheduled appointment, you may be charged the full session fee. Emergency situations are exceptions to this policy and will be evaluated and discussed on a case-by-case basis.

COMMUNICATION

Often, we are not immediately available by telephone. When we are unavailable, you can leave a message on our confidential voice mail. It may be 24-48 hours before we can return your call. We check our phone for text messages regularly and can respond more quickly by Text. We will make every effort to return your call on the same day, with the exception of weekends and holidays.

EMAIL

ECS requests that E-mail communication be kept to a minimum, limiting communication to administrative concerns or general information. To protect your confidentiality, please do not discuss confidential information by email as it is not a secure method of communication and we cannot guarantee confidentiality. Any email correspondence may become a part of your clinical record.

Email should never be used to contact us in the event of an emergency.

Informed Consent to Communicate Via Email:

ECS will only communicate with you by email with your informed consent. I have read and understand the above information and wish to exchange communications via email.

☐ Yes ☐ No _____ (Initials)

TEXT MESSAGING

To protect your confidentiality, ECS requests that text communication be kept to a minimum. This would include communication via administrative concerns, such as cancellations and scheduling changes. Please do not discuss confidential information via text message as it is not a secure method of communication and we cannot guarantee confidentiality.

Informed Consent to Communicate Via Text Messaging:

ECS will only communicate with you by text with your informed consent. I have read and understand the above information and wish to exchange communications via text messaging.

☐ Yes ☐ No _____ (Initials)

Other forms of Electronic Communication

Please do not use any personal messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact ECS. These sites are not secure or confidential, instead use any of the Elliant email addresses.

Social Media

We do not accept friend or contact requests from current or former clients on any social or networking site (Facebook, LinkedIn, etc.). We believe adding clients as friends or contacts on these sites may compromise your confidentiality, our respective privacy, and the boundaries of our therapeutic relationship.

FINANCIAL AGREEMENT AND AUTHORIZTION FOR TREATMENT

I have read the preceding information and I understand my rights as a client. I authorize treatment of the person named below and agree to pay all fees as stated above.

_____	_____	___/____/_____
Print Client Name or Responsible Party	Signature Client or Responsible Party	Date
_____	_____	___/____/_____
Print Joint Client Name	Signature Joint Client Name	Date

CLIENT FORMS

Embracing the Courage to Change

Elliant Counseling Services

Confidential Client Information

Today's Date: ___/____/_____

Personal Information

Last Name: _____ First: _____ Middle Initial: _____

Address: _____-

_____

City: _____State: _____Zip_____

Home Phone: _____ Work: _____ Cell: _____

Email: _____ Birthdate: ___/____/_____ Age: _____ Male: ☐ Female: ☐

Occupation: _____ Highest Level of Education: _____

Single: ☐ Married: ☐ Partnered: ☐ Divorced: ☐ Separated: ☐ Engaged: ☐

If Married/Partnered, how long? _____ Spouse/Partner's name: _____

Is your spouse/partner supportive of you seeking counseling? ☐ Yes ☐ No ☐ Unsure

Names/Ages of Children (within or outside the relationship): _____

_____

_____

In case of emergency, please notify: _____

Relationship: _____ Phone: _____

Referral Information

How did you hear about Elliant Counseling Services? _____

Do I have your permission to send a simple "Thank you" note to the referral source? Thank you note would read something like: "Thank you for your recent referral. I appreciate your support of our practice."

☐ Yes, you can send such a note _____ (Initial)

☐ No, please do not acknowledge I called _____ (Initial)

Medical History

Are you currently under medical care? ☐ Yes ☐ No If yes, please describe: _____

_____

Physician's Name_____ Phone: _____

Do you take any prescription medications? ☐ Yes ☐ No

If yes, list name, dosage and frequency: _____

_____

Other significant medical history: _____

_____

Counseling History

Have you ever seen a counselor/therapist/psychologist/psychiatrist? ☐ Yes ☐ No

Please provide, Name: _____ Date: ___/____/_____ Location: _____

When was your last appointment with any of the above? _____

Reason for Counseling

Why are you seeking counseling now? _____

_____

_____

_____

_____

How long have these concerns been causing you distress? _____

How do you hope counseling will help? _____

_____

_____

FUNCTIONAL ASSESSMENT QUESTIONNAIRE

1. Have you ever been hospitalized for psychological problems? Yes ☐ No ☐ If yes, give date(s), places, and problem(s): _____
_____
_____

2. Rate your average **daily mood level** (10 = high, 1 = low): _____ Are there major highs or lows? Yes ☐ No ☐

3. Have you ever attempted suicide? Yes ☐ No ☐ If yes, share when and how: _____
_____
_____
_____

4. Has any close relative attempted or committed suicide? Yes ☐ No ☐ If yes, share who, when and how.
_____

5. Do you experience significant problems with any of the following **behaviors** (circle all that apply)?
Drug Use Anger Management Conflicts at Home Difficulties Concentrating Sleep Disturbance
Drinking Problem Eating Problems Conflicts at Work/School Suicidal Thoughts Tends to Isolate
If yes, describe when these behavior(s) began and how they are impacting you now?
_____
_____
_____
If yes to drinking or using drugs, how much of a problem is it today and have you ever been in treatment for this problem? If so, where and when did treatment occur?
_____
_____
_____

6. Do you experience significant problem with any of the following **emotions/ feelings** (circle all that apply)?
Angry (mad) Depressed (sad) Anxious or Panicky (scared) Hopeless Helpless
Overwhelmed Worthless Directionless Exhausted Alone
If yes, describe how long you have been feeling these particular emotions and feelings?
_____
_____
_____

7. Do you experience significant problem with any of the following **physical sensations** (circle all that apply)?
Headaches Dry Mouth Reduced/Increased Appetite Tremors Floating Sensation
Palpitations Tingling Twitching Blackouts Numbness
If yes, describe how long you have been experiencing these sensations?
_____
_____
_____

NOTICE OF PRIVACY POLICIES AND PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Elliant Counseling Services, PC ("ECS") believes it may be a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) and thus provides its clients with this Notice of Privacy Policies & Practices and complies with the procedures and protocols listed herein. If ECS is determined not to be a covered entity under HIPAA, it will still follow this Notice of Privacy Policies & Practices regarding use and disclosure of PHI; however, the client may not be entitled to the rights set forth in the "Your Rights as a Client" section.

Given the nature of ECS's work, it is imperative that it maintains the confidence of client information that it receives in the course of its work. ECS is a mental health practice that provides mental health services. ECS's practice works solely to provide the best counseling treatment options to its clients. ECS is prohibited from releasing any client information to anyone outside immediate staff, employees, interns, and/or volunteers except in limited circumstances in accordance with this Notice of Privacy Policies and Practices. Discussions or disclosures of protected health information ("PHI") within the practice are limited to the minimum necessary that is needed for the recipient of the information to perform his/her job. Please review this Notice of Privacy Policies and Practices ("Notice of Privacy Policies"). It is my policy to:

1. fully comply with the requirements of the HIPAA General Administrative Requirements, the Privacy and Security Rules;
2. provide every client who receives services with a copy of this Notice of Privacy Policies;
3. ask the client to acknowledge receipt when given a copy of this Notice of Privacy Policies;
4. ensure the confidentiality of all client records transmitted by facsimile;
5. obtain from each client an informed Authorization for Release of Protected Health Information form when required.

ECS is required to follow all state and federal statutes and regulations including Federal Regulation 42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164, governing testing for and reporting of TB, HIV AIDS, Hepatitis, and other infectious diseases, and maintaining the confidentiality of PHI.

PHI refers to any information that I create or receive, and relates to an individual's past, present, or future physical or mental health or conditions and related care services or the past, present, or future payment for the provision of health care to an individual; and identifies the individual or there is a reasonable basis to believe the information can be used to identify the individual. PHI includes any such information described above that I transmit or maintain in any form, this includes Psychotherapy Notes. HIPAA and federal law regulate the use and disclosure of PHI when transmitted electronically.

YOUR RIGHTS AS A CLIENT

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your mental health record

- You can ask to see or get an electronic or paper copy of your mental health record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee to fulfill your request.
- If we deny your request, in whole or in part, we will let you know why in writing and whether you have the option of having the decision reviewed by an independent third-party.

Ask us to correct your mental health record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.
- Please review the Consent for Communication of Protected Health Information by Non-Secure Transmissions.
- You are required to "opt-in" to receive communications electronically as set-forth in the Consent for Communication of Protected Health Information by Non-Secure Transmissions. If you choose not to "opt-in" to receive electronic communications, we will not communicate with you via electronic means.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Additional Restrictions

- You have the right to request additional restrictions on the use or disclosure of your mental health information. However, we do not have to agree to that request, and there are certain limits to any restriction. Ask us if you would like to make a request for any restriction(s).

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints**.**
- We will not retaliate against you for filing a complaint.
- You may also file a complaint with the Colorado Department of Regulatory Agencies, Division of Professions and Occupations, Mental Health Section; 1560 Broadway, Suite 1350, Denver, Colorado, 80202, 303-894-2291; DORA_Mentalhealthboard@state.co.us. Please note that the Department of Regulatory Agencies may direct you to file your complaint with the U.S. Department of Health and Human Services Office for Civil Rights listed above and may not be able to take any action on your behalf.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A use of PHI occurs *within* a covered entity (i.e., discussions among staff regarding treatment). A disclosure of PHI occurs when ECS reveal PHI to an outside party (i.e., ECS provides another treatment provider with PHI, or shares PHI with a third party pursuant to a client's valid written authorization).

ECS may use and disclose PHI, without an individual's written authorization, for the following purposes:

1. Treatment: disclosing and using your PHI by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members and for coverage arrangements during your therapist's absence, and for sending appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

2. Payment: disclosing and using your PHI so that ECS can receive payment for the treatment services provided to you, such as: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization of review activities.
3. Health Care Operations: disclosing and using your PHI to support ECS's business operations which may include but not be limited to: quality assessment activities, licensing, audits, and other business activities.

Uses and disclosures for payment and health care operations purposes are subject to the minimum necessary requirement. This means that ECS may only use or disclose the minimum amount of PHI necessary for the purpose of the use or disclosure (i.e., for billing purposes ECS would not need to disclose a client's entire medical record in order to receive reimbursement. ECS would likely only need to include a service code and/or diagnosis etc.). Uses and disclosures for treatment purposes are not subject to the minimum necessary requirement.

ECS is required to promptly notify you of any breach that may have occurred and/or that may have compromised the privacy or security of your PHI.

Confidentiality of client records and substance abuse client records maintained are protected by federal law and regulations. It is ECS's policy that a client must complete an Authorization for Release of Protected Health Information it provides prior to disclosing health information to another individual and/or entity for any purpose, except for treatment, payment, or health care operations in accordance with this Notice of Privacy Policies.

Absent the above referenced form, other than for treatment, payment, or health care operations purposes, ECS is prohibited from disclosing or using any PHI outside of or within the organization, including disclosing that the client is in treatment without written authorization, unless one of the following exceptions arises:

1. Responding to lawsuit and legal actions (Disclosure by a court order, in response to a complaint filed against ECS, etc. This does not include a request by you or another party for your records).
2. Disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.
3. Help with public health and safety issues (Client commits or threatens to commit a crime either at ECS's office or against any person who works for ECS; A minor or elderly client reports having been abused or there is reasonable suspicion that abuse has or will take place; Client is planning to harm another person, including but not limited to the harm of a child or at-risk elder; Client is imminently dangerous to self or others).
4. Address workers' compensation, law enforcement, and other government requests.
5. Respond to organ and tissue donation requests.
6. Business Associates: ECS may enter into contracts with business associates to provide billing, legal, auditing, and practice management services that are outside entities. In those situations, protected health information will be provided to those contractors as needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.
7. In compliance with other state and/or federal laws and regulations.

The above exceptions are subject to several requirements under the Privacy Rule, including the minimum necessary requirement and applicable federal and state laws and regulations. See 45 C.F.R. § 164.512. Before using or disclosing PHI for one of the above exceptions, ECS's staff must consult its Privacy Officer (Linnaya Widhalm, LPC, CAC III, MAC, CSAT, 303-241-1080, Linnaya@ElliantCounseling.com) to ensure compliance with the Privacy Rule. Violation of these federal and state guidelines is a crime carrying both criminal and monetary penalties. Suspected violations may be reported to appropriate authorities, as listed above in the "Client Rights" section, in accordance with federal and state regulations. Know that ECS will never market or sell your personal information without your permission.

SPECIAL AUTHORIZATIONS

Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

Psychotherapy Notes: ECS may keep and maintain "Psychotherapy Notes", which may include but are not limited to notes ECS makes about your conversation during a private, group, joint, or family counseling session, which is kept separately from the rest of your record. These notes are given a greater degree of protection than PHI. These are not considered part of your "client record." ECS will obtain a special authorization before releasing your Psychotherapy Notes.

HIV Information: Special legal protections apply to HIV/AIDS related information. ECS will obtain a special written authorization from you before releasing information related to HIV/AIDS.

Alcohol and Drug Use Information: Special legal protections apply to information related to alcohol and drug use and treatment. ECS will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment.

You may revoke all such authorizations to release information (PHI, Psychotherapy Notes, HIV information, and/or Alcohol and Drug Use Information) at any time, provided each revocation is in writing, signed by you, and signed by a witness. You may not revoke an authorization to the extent that (1) ECS has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

As a covered entity under the Privacy and Security Rules, ECS is required to reasonably safeguard PHI from impermissible uses and disclosures. Safeguards may include, but are not limited to the following:

1. Not leaving test results unattended where third parties without a need to know can view them.
2. Any PHI received as an employee, intern, or volunteer about a client or potential client, may not be used or disclosed for non-work purposes or with unauthorized individuals. ECS may only use and disclose such PHI as described above.
3. When speaking with a client about his or her PHI where third parties could possibly overhear, the conversation will be moved to a private area.
4. Seeking legal counsel in uncertain situations and/or incidences.

5. Obtaining a Business Associates Agreement with those third-parties that have access to and/or store client information. Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services.
6. Implementing FAX security measures.
7. Obtaining your consent prior to sending any PHI by unsecure electronic transmissions.
8. Providing information on my electronic record-keeping.

YOUR CHOICES

For certain health information, you can tell ECS (verbal authorization) your choices about what it shares. If you have a clear preference for how ECS shares your information in the situations described below, talk to ECS. Tell ECS what you want it to do, and it will follow your instructions. ECS may request you sign a separate document if you authorize it to share certain PHI. You may revoke authorization at any time for future disclosure.

In these cases, you have both the right and choice to tell ECS to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell ECS your preference, for example if you are unconscious, ECS may go ahead and share your information if ECS believes it is in your best interest and for your care/treatment. ECS may also share your information when needed to lessen a serious and imminent threat to public health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Changes to the Terms of this Notice

ECS can change the terms of this notice, and the changes will apply to all information ECS has about you. The new notice will be available upon request, in ECS's office, and on the website.

This notice is effective 11-2018.

_____ _____

Client Signature Date

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Acknowledgement of Purpose of Support Sessions

As part of a successful treatment plan and to assist in relationship mending and development, support sessions can be conducted. It is to be understood that support sessions are not considered to be either couples or family services. A support session is to help you understand the primary client that is receiving services. Support sessions can occur after every third session with primary client.

If you contact me by phone, email, fax, etc., I will not hold secrets and this information will be shared in the next session with primary client.

_____	_____	___/___/_____
Primary Client Name (printed)	Primary Client (Signature)	Date
_____	_____	___/___/_____
Client Name (printed)	Client Signature	Date
_____	_____	___/___/_____
Client Name (printed)	Client Signature	Date

Administrative Consent to Disclose Personal Information

In order to maintain confidentiality of your file, Elliant Counseling Services, PC must adhere to the privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996(HIPAA), and also the Colorado State Statue 12-43-218. Disclosure of confidential communications. This signed authorization will allow Donya Evans the Business Office Manager and Scheduling Coordinator at ECS, to handle all information in your file, including but not limited to the following:

Psychological Test Reports
Social History Summary
Medical Records (+ medications received)
Billing and Financial Information

Counseling Records
Status of Treatment and/or Goals
Email & phone communications

I understand client files may be maintained up to five years after discontinued/termination of treatment with:

_____ (name of Therapist), and I may withdraw this authorization in writing at any time prior to its expiration.

_____

Client's Signature Today's date

A HIPAA Business Associate Contract for Donya Evans is on file and available upon request.

Consent to Counseling for Couples

When working with you, it is expressly understood that my client is both you and your relationship and each of you as individuals. In order to maintain fidelity to both you and to your relationship, there are important agreements for us to make.

1) I may potentially share any information conveyed to me by either of you with the other member of the couple. At times, instances arise where one partner in a couple wants to tell me something without the other one knowing it. Please do not expect me to keep secrets where doing so jeopardizes the therapeutic work or my relationship with either of you or your relationship. Please be aware that information you choose to share with me that is particularly pertinent to both of you may come out in counseling. This pertains to all face-to-face, written, phone conversations, and messages.
2) If I meet with one or both of you in individual sessions, we will likely share the contents of that meeting with the partner at the next couple's session.
3) All information revealed to me by each of you shall be considered strictly confidential and I will not reveal it to any other person without mutual consent of both of you, except as described in the legal exceptions of (a) imminent danger to self or to others (suicidal and homicidal) (b) legal requirements to report child abuse (c) grave disability from a mental illness. **Furthermore, each of you waives the right to subpoena my records or me for testimony or production.** This further supports my fidelity to both of you and to your relationship, and discourages my taking sides in a legal dispute.
4) The continued participation by each person is voluntary. Either person may suspend or terminate counseling at her or his individual request.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES. I CONSENT TO COUPLES COUNSELING UNDER THE AGREEMENT STATED ABOVE.

_____	_____	_____
Client Name (printed)	Client Signature	Date

_____	_____	_____
Client Name (printed)	Client Signature	Date

Limitation on Confidentiality in Couple or Family Therapy

This written policy is intended to inform you, the participants in family therapy or couples therapy, that when I agree to work with a couple or family, I consider the couple or family (A Treatment Unit) to be a patient. For instance, if there is a request for the treatment records of the couple or family, I will seek authorization of all members of the treatment unit before I release confidential information to the third party. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient and the treatment unit.

During the course of my work with a couple or family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or couple, unless otherwise indicated. If you are involved in one or more such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, I would seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit; that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgement as to whether, when, and to what extent I will make disclosures to the treatment unit, and I will also, if appropriate, first give the individual or smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "Limitation on Confidentiality in Couple or Family Therapy" policy is intended to allow me to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of _____(couple/family or other unit) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had the opportunity to discuss its contents with _____(the therapist), and that we enter couple/family therapy in agreement with this policy.

Dated: _____Signature: _____

Dated: _____Signature: _____

Dated: _____Signature: _____

RELEASE / To / From / Between the following

Name	**Name**
Center/ Agency	**Center / Agency**
Phone / Fax	**Phone / Fax**

The information listed below contained in the record of:

_____

I request and authorize the above-named therapist to release/request information specified below to the organization, agency, or individual on this request. I understand that the information to be released includes verbal and/or written information regarding the following condition(s):

_____Psychological or Psychiatric Conditions **_____Substance Abuse**

INFORMATION REQUESTED:

I authorize the following information to be released:

___Discharge Summary **___Educational Information**
___Psychiatric History & Assessment **___Status of Attendance & Involvement in Treatment**
___Psychological Testing **___Medications, Prescriptions, & Diagnostic Info.**
___Social History Summary **___Medical History & Physical Exam**
___Treatment Plan, Goals, and Objectives **___Final Diagnosis**
___Other (List)_____

PURPOSES:

I understand that this information will be used for:

___Purposes of further evaluation **___ Other_____**

AUTHORIZATION:

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. REDISCLOSURE OF MY RECORDS BY THOSE RECEIVING THIS AUTHORIZATION IS PROHIBITED. I hereby release both of the above parties from any liabilities which may result from furnishing the information released or requested. Without my expressed revocation, this consent will automatically expire 60 days from the dates signed below.

OTHER CONDITIONS:

A copy of this authorization or my signature thereon may be utilized with the same effectiveness as an original.

X _____ _____
Signature of Client **Date**

X _____ _____
Signature of Witness / Parent (if applicable) **Date**

(Parental signature required for clients under the age of 15. For clients age 16-17, both client and parent signatures are required.)