

Southside Counseling Center, LLC

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Informed Consent and Privacy Practices Notification

Maintaining confidentiality generally means that anything that occurs in psychotherapy is not divulged by the therapist. This is mostly true, although there are some situations that make exceptions to this rule. **Privilege** refers to the client's ability to protect information in a legal proceeding. With these definitions in mind, I acknowledge and consent to the following:

Exceptions to Confidentiality and/or Privilege

Mandated reporting by therapist

1. If a therapist suspects that a client is a danger to him/herself physically or incompetent mentally
2. If a therapist suspects that a client intends to bring physical harm to others
3. If a client has physically, sexually, or (severely) emotionally harmed or neglected a minor or a dependent adult

Situations in which privilege does not apply or is limited

4. If a client brings a lawsuit against the therapist
5. If another person is in the room
6. If a court requires the client or therapist to testify
7. If the client is being evaluated for a third party
8. If a client, or member of a client's family, commits a crime on the premises or against any therapist for, or employee of, Southside Counseling Center, LLC

Items 1, 2, and 3 above are extreme situations that are exceptions to confidentiality and in which the therapist MUST file a report with the appropriate agency. All other reasonable means would be exhausted prior to using this option; even then, the client's cooperation would be encouraged.

Disclosure of Information

Your therapist can provide information to a third party only if you give written permission to do so. Therefore, any time you give such permission, confidentiality is limited. No information pertaining to specifically-named clients will be shared among therapists without clients' written permission, except when another therapist is providing coverage during emergencies, vacations, etc. Therapists at Southside Counseling Center do occasionally engage in peer consultation, in order to provide clients with the highest caliber of service. In these cases and in most situations listed above, the therapist can reveal information only to someone who has a *need to know*, and entire records or irrelevant information may not be disclosed. Individuals entering therapy for reasons directly related to substance abuse have privacy rights in addition to those specified on this form. Whenever information will be shared with other persons, their names or positions will be specifically listed, and every effort will be made to ensure that the receiving person also maintains confidentiality. The major situations in which the therapist may disclose such information with written permission are:

1. If a client is being evaluated or treated for a third party (disability, custody, etc.)

2. If a client requests or gives permission for information to be obtained from or provided to a third party (therapist, physician, teacher, employer, etc.)
3. If a client's therapist is being supervised (the supervisor may know the details of the case and is also bound by confidentiality)
4. If a client is using third-party coverage (insurance) to pay for therapy
5. In the event of the disability or death of a client's therapist

In addition to the above, I understand that special circumstances apply to group, couple, parent-child, and family therapy, as well as any time I may involve another person in treatment. *Basically, other individuals in the room are not bound by privilege and may possibly not hold all information confidential; the therapist is not responsible for disclosure by these individuals.* In situations where I am in therapy with another person (e.g., a spouse or child), and secret information is revealed by one person to the therapist, it is understood that the therapist will not reveal the information (unless mandated by law), but may determine that it is not workable to continue treatment. Should this situation arise, the therapist will discuss it with me thoroughly.

It is this Center's policy that when minors participate in the counseling process, any parent(s) holding **legal** custody must sign this form, thus acknowledging and agreeing to participation by the minors involved. A legal custodial parent not participating in counseling with his/her children has limited access to privileged information, as the above-referenced rules of confidentiality apply. Minors entering therapy for the specified purpose of resolving substance abuse problems have additional privacy rights mandated by federal law.

I further understand that SCC employees assigned to schedule, record receipts from, and bill clients and third-party reimbursers have access to client records. Client records are stored inside locked cabinets within an office to which the public has no access. Billing and scheduling information are stored electronically; access is guarded by passwords and encryption software. By law, client records are kept for at least seven years; records remain the property of SCC. I may have access to my records after submitting a written request (\$.20/pg photocopy charge), although it may be best for my therapist to discuss with me the items contained in those records or to provide me with a summary for a specific purpose.

Payment of Fees

I agree to pay my insurance co-pay at each session and to notify SCC immediately of any changes to my coverage. I understand that I am responsible for, and I agree to pay, all charges not paid by my insurer. If I am not using insurance to pay for counseling services, my self-pay amount is due at each session. If I refuse to pay such charges, I agree that SCC has the right to suspend services until payment has been made. SCC retains the right to collect from me twenty-five dollars (\$25) for any failure to attend session without prior notice or for cancellations occurring within 24 hours of my scheduled appointment. I also agree to pay SCC a fee of \$75 per hour if documentation is required for a disability or legal claim.

If I demonstrate a recurrent pattern of late cancellations and/or no-shows for my scheduled appointments, I understand that my therapist may choose to refer me to another practice.

Client: _____

Date: ___/___/___

Client: _____

Date: ___/___/___