

Rev 1/2012 [Staff use only: Policy Face Sheet Ins Card ID faxed/scanned]

COUNSELING POLICIES

PATIENT INFORMATION

PATIENT FULL NAME			DATE OF BIRTH		
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER		EMPLOYMENT <input type="checkbox"/> EMPLOYED <input type="checkbox"/> FULL TIME STUDENT <input type="checkbox"/> PART TIME STUDENT <input type="checkbox"/> OTHER		
ADDRESS			CITY/STATE/ZIP		
HOME PHONE		LEAVE MSG? <input type="checkbox"/> YES <input type="checkbox"/> NO	CELL PHONE		LEAVE MSG? <input type="checkbox"/> YES <input type="checkbox"/> NO
EMERGENCY CONTACT NAME			EMERGENCY CONTACT PHONE		

BILLING INFORMATION

BILLING FULL NAME			RELATION TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> OTHER		
BILLING ADDRESS			CITY/STATE/ZIP		
BILLING PHONE		LEAVE MSG? <input type="checkbox"/> YES <input type="checkbox"/> NO	EMAIL ADDRESS		RECEIVE STATEMENT VIA EMAIL <input type="checkbox"/> YES <input type="checkbox"/> NO

REQUIRED SIGNATURES

I clearly understand that I am ultimately responsible for payment to Rum River Counseling, Inc. for any and all services rendered due at the time of the visit or upon receiving explanation of benefit information from my insurance company, whichever comes first. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. I understand that if I should default on any payment obligations as called for in this agreement, Rum River Counseling, Inc. will have the right to forward my information to collections, and in the event that it becomes necessary to utilize a collection agency to resolve a past due account, up to an additional 30% will be assessed to my account to cover the costs of this action. Rum River Counseling, Inc. will not be obligated to provide continuing services to any client who includes Rum River Counseling, Inc. as a creditor in any bankruptcy filing. My signature below indicates that I fully understand and agree to these terms.

BILLING SIGNATURE(S) (LEGAL GUARDIAN) – Required for services	DATE
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INFORMED CONSENT: My signature below indicates that I am consenting to treatment at Rum River Counseling, Inc., and have received and understand the contents of the Counseling Policies, including the Notice of Privacy Practices (HIPAA). If I have questions, the information has been explained and/or summarized for me.



SIGNATURE(S) (LEGAL GUARDIAN) – Required for services	DATE
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I authorize Rum River Counseling, Inc. to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Rum River Counseling, Inc. I understand that I am responsible for payment for services rendered by Rum River Counseling, Inc. regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify Rum River Counseling, Inc. immediately whenever I have changes in my health condition or health plan coverage in the future.

SIGNATURE(S) (LEGAL GUARDIAN) – Required to bill insurance	DATE
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PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION	PRIVATE PAY
Copy of both sides of the insurance card(s) needed at intake.		
INSURANCE COMPANY	INSURANCE COMPANY	PRIVATE PAY AMOUNT:
COPAY: \$	*DEDUCTIBLE: \$	CO-INSURANCE: %
COPAY: \$	*DEDUCTIBLE: \$	CO-INSURANCE: %
		\$ /INTAKE
		\$ /FOLLOW-UP

*** A DEDUCTIBLE or Out of Network Insurance Coverage REQUIRES A CREDIT CARD ON FILE**

<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		CARD NUMBER	EXP DATE	CVV CODE
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I hereby give consent to charge my credit card below for any outstanding balance at the end of each month such as deductibles, co-payments or other amounts my carrier determines as payable by me.

CARD HOLDER SIGNATURE	DATE
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COUNSELING POLICIES

*Rum River Counseling, Inc. is a group of private practice of mental health professionals.
We are dedicated to providing counseling services that improve the lives of individuals, couples and families of all ages.*

What is therapy and how does it work?

Therapy is the process of solving emotional problems by talking with a person professionally trained to help people achieve a more fulfilling individual life, marital/couple relationship, or family relationships.

The process of change will, in many ways, be unique to your particular situation. Who you are as a person will help to determine the ways in which you go about changing your life.

The process of change begins by first clearly defining the problem, and then discussing your thoughts and feelings, understanding the origin of the difficulty and developing new skills and healthy attitudes about yourself and others.

As the client, you have the right to ask your therapist questions about his or her qualifications, background, and therapeutic orientation. The most important factor in the success of therapy is good communication between therapist and client.

In some instances, talking about your difficulties may exacerbate your symptoms, however over time you should see an improvement. In addition, not all individuals benefit from therapy or working with a particular therapist.

If at any time during the therapy you have questions about whether or not the treatment is effective, feelings about something your therapist has said or suggested or need clarification of our goals, do not hesitate to bring this up in your session.

INTAKE APPOINTMENT

Please bring the following REQUIRED items to your intake appointment:

- ✓ Completed Personal History form
- ✓ Completed and Signed Counseling Policies forms
- ✓ Completed PHQ (adults) or SDQ (minors)
- ✓ Photo ID (of legal guardian, if client is a minor)
- ✓ Insurance card(s) (also bring MA card if you have one)
- ✓ Payment for copay or other financial responsibility (cash, check, credit/debit card, or HSA card)
- ✓ Custody Agreement court documents & physician note (minors with divorced parents and only one parent signature) – must be received a *minimum of 1 business day BEFORE the scheduled appointment.*

If you are unable to complete, or forget to bring your forms, please arrive about 15-20 minutes early to complete a new Personal History form located in the wall file in the waiting area. All forms will be reviewed during your intake session. If you have any questions, please ask your therapist during your appointment.

CONFIDENTIALITY POLICY

The staff and therapists at Rum River Counseling, Inc. have an obligation to respect your right to confidentiality for the information you share within this clinical setting. Confidentiality of client information is governed by federal law (Health Information Portability and Accountability Act) and by state law.

The State of Minnesota laws impose some limitations to your rights to confidentiality. The following is a list of situations in which you may lose your right to confidentiality:

- ✓ We are obligated to report any maltreatment of minors or vulnerable adults. This includes physical abuse, sexual abuse or neglect.
- ✓ We are obligated to report any prenatal exposure to controlled substances.
- ✓ We are obligated to report any serious harm you intend to inflict on yourself or another.
- ✓ We are obligated to share information if directed by Court Order to conform to state or federal law, rules or regulations.
- ✓ We are obligated to share information with licensing boards, which is pertinent to a disciplinary proceeding involving a provider.

If you are a minor, you have a limited right to privacy in that your parents may have access to your records. However, if the therapist believes that sharing this information will be harmful to you, confidentiality will be maintained to the limits of the law.

Group Therapy: The right to confidentiality is addressed in the group setting. However, RRC and group therapists are not responsible for any breaches of confidentiality by group members.

There are instances in which individuals associated with Rum River Counseling, Inc. have duties that require access to the information you may share for claim processing, scheduling, reports, consultations, etc.

INSURANCE BILLING

We are in-network providers for most major insurance companies. As a courtesy to you, we work directly with your insurance and will make every effort possible to bill your insurance company.

- Once your appointment has been scheduled, we will verify your insurance benefit coverage and obtain any necessary authorizations for you.
- Verification of benefit coverage is not a guarantee of claim payment. All benefits are subject to the terms and conditions (e.g. authorizations, network requirements) outlined in your member contract with your insurance company. We have no authority to make representations to you regarding coverage of items or services covered.
- It will be important for you to understand your benefit coverage. For benefit coverage questions, please call the customer/member service number on the back of your insurance card. The insurance verification worksheet provided on our website can assist you during the call. It is your responsibility to check before your initial visit to know your plan's limitations, deductibles and exclusions.
- In compliance with health insurance contracts, RRC requires that all copayments are collected for payment at the time of service and that all coinsurance and deductible amounts are collected immediately following insurance claim processing. We do not have the ability to waive copayments, deductibles, or coinsurance amounts due, as this is a violation of the contract we have with your insurance company.
- You are responsible to pay the full fee for all services at the time of your visit, unless you have coverage through an insurance plan for which we have participating providers. Please bring your insurance card to the intake appointment and provide it to your therapist for copying.
- It is your responsibility to provide us with updated information if your insurance company changes or your coverage terminates. If the insurance information you provide to us is later determined to be inaccurate, resulting in denial of your claim, then you will be responsible for the amount denied by your carrier.
- You are responsible for charges not eligible and/or covered by your medical insurance plan. If you discontinue care for any reason, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

-Per your agreement with your insurance company, it remains your responsibility to immediately pay any copayments, deductibles, coinsurances or other amounts your insurance carrier determines as payable by you.


-Your insurance company informs you of this amount payable by sending you an explanation of benefits (EOB) at the same time that we are informed of this amount.

-Upon receiving this information, please remit payment by mail, online at our website, or at your next scheduled appointment (if scheduled appointment occurs within 1 week of receiving your EOB) this payment is to be collected by your therapist.

-Because we are a "fee for service" provider, billing statements from Rum River Counseling, Inc. will not automatically be sent - should you need a statement or payment itemization, please inform your therapist, and we will provide this for you upon request.

<p>TELEPHONE CONSULTATIONS</p> <p>Time spent with you on the telephone by your mental health professional other than for appointment information may be charged at a prorated hourly charge.</p>	<p>PREPARATION OF FORMS AND REPORTS</p> <p>These require chart review and often, discussion with the client. There will be a minimum charge of \$25 up to a maximum of \$200 per hour.</p>
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<p>APPOINTMENTS</p> <p>-We realize that on occasion you will not be able to make a scheduled appointment. You can call our scheduler at 763-482-9598 or call 763-754-0903 and leave a cancellation message on your therapist's voice mail if our scheduler is not available.</p> <p>-However, please remember that this time has been reserved for you alone, so our policy is to charge \$85 for missed appointments or \$50 for cancelations without 24-hour advance notice.</p> <p>-Because we have many people who are waiting for appointments, clients who frequently (more than two times) fail or cancel their appointments without a 24-hour notice will not be rescheduled and will be subject to "Same Day" availability.</p> <p>-Successful on-going therapy requires a commitment on the part of the client. <i>It is important that you keep your appointment if at all possible.</i></p>	<p>AFTER-HOURS EMERGENCIES</p> <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> <p><i>For after-hours emergencies, or if you need immediate assistance, call 911 or visit your local emergency room, medical group, or primary care physician.</i></p> </div> <p>Therapists at Rum River Counseling, Inc. are not available after usual business hours for emergencies. To leave a message for your therapist, you may call 763-482-9598 or 763-754-0903 and your therapist will return your call as soon as possible. Messages are generally checked weekdays between 9:00 AM and 5:00 PM.</p> <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> <p>Some local crisis phone numbers include:</p> <ul style="list-style-type: none"> -Crisis Connection: 612-379-6363 or toll free 1-866-379-6363 -Anoka County RiverWind Crisis Services: 763-755-3801 -Ramsey County Crisis Services: 651-266-7900 -Hennepin County Crisis Services: children 612-348-2233 -Hennepin County Crisis Services: adult 612-596-1223 -Carver County Crisis Services: 952-442-7601 -Crow Wing County Crisis 218-828-4357 or 800-462-5525 </div>
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<p>MANAGING YOUR ACCOUNT BALANCE</p> <p>If mailing, please remit payment to: Rum River Counseling, Inc. 2705 Bunker Lake Blvd. NW Suite 100 Andover, MN 55304</p> <p>Online payments: Visit our website at www.rumrivercounseling.com to pay using our Secure Online Form or to pay with .</p>	<p>CHECK POLICY</p> <p>To ensure proper credit, please make checks payable to Rum River Counseling, Inc.</p> <p>There will be a \$40 fee for returned checks. Thereafter, payment will only be accepted in the form of cash, credit card or money order.</p>
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FEES

Insurance Code	Description	Unit	Price
90801/90802	Intake	45-50 min	\$200
90806/90812	Individual Therapy	45-50 min	\$150
90847/90846	Couple/Family Therapy	45-50 min	\$150
90853/90849	Group Therapy	60-90 min	\$150
90808/90814	Individual Therapy	75-80 min	\$250
90804/90810	Individual Therapy	20-30 min	\$75
96101/96102/96118/96119	Psychological/Neurological Testing	TBD	\$500-2500
Not Billable to Insurance	Late Cancelation / No show	n/a	\$50 / \$85
Not Billable to Insurance	Returned Check (NSF)	n/a	\$40
Not Billable to Insurance	Professional Consultation Services	60 min	\$250
Not Billable to Insurance	Fees, Phone calls, Letters, & Reports	1-15 min	\$25+
Not Billable to Insurance	Court Appearances**	45-50 min**	\$250**

CONFIDENTIALITY AND RELEASE OF RECORDS

All information regarding patients is considered strictly confidential and will not be given out to anyone without your written consent. In the event of request for transfer of records, the records will be forwarded upon completion of a consent form and a payment fee based on the current MN Dept of Health maximum allowed. Copies of records are available for a \$16.03 processing fee, plus \$1.22 per page for copying.

"Nobody can go back and start a new beginning, but anyone can start today and make a new ending." ~Maria Robinson, author

****COURT & LEGAL PROCEEDINGS**

RRC does NOT provide disability determination, custody studies, or handle court issues.

- RRC providers do not perform court evaluations nor do they appear in court on behalf of individuals, children or adults. RRC services are designed to assist in alleviating problems through individual or relational psychotherapy. RRC providers are not trained for, nor do they maintain records with the intended purpose of court involvement.
- In addition, the legal process is such that we may be compelled to reveal information about you that could affect you negatively or undermine your relationship with your therapist. Because the client-therapist relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, testify whether factual or in an expert nature, in court or deposition.
- If you wish forms for determination of mental illness, disability, court involvement with custody or assessments to be completed, we would be happy to refer you to practitioners in the area who offer this service.
- Should we be called to court by a judge court order, or our records court ordered or subpoenaed, we will charge the full amount applicable under law for our services. Copies of records are available for a \$16.03 processing fee, plus \$1.22 per page for copying.
- In the event that it is necessary, by court order or by subpoena, for the therapist to testify before any court, arbitrator, or other hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for his or her services, (including but not limited to: travel, necessary expenditures (copies, parking, meals, and the like), time spent speaking with attorneys, reviewing records and preparation of reports) @ the rate of \$250.00 per hour, rounded to the nearest half hour.
- The client further agrees to pay a retainer fee of \$2,000.00 two weeks prior to the appearance, presentation of records, or testimony requested. Checks will not be considered an acceptable form of payment for these services.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist at RRC to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. My informed consent signature shows that this litigation limitation is clearly understood and agreed to.

CLIENT BILL OF RIGHTS

RRC does not discriminate on the basis of religion, race, gender, marital status, age, sexual orientation, national origin, previous incarceration, disability or public assistance status.

Every client:

- shall be informed prior to, or at the time of, the intake appointment of services available at RRC and of any financial charges that are the client's responsibility to pay beyond the coverage of health insurance.
- can expect complete and current information concerning his or her diagnosis and individual treatment plan in terms he or she can understand.
- shall have the right to know by name, and the competencies of, the licensed mental health professional responsible for coordination of his or her treatment.
- shall have the freedom to place grievances and recommend changes in policies and services to RRC staff free from restraint, interference, coercion, discrimination, or reprisal.

In addition to the rights listed above, services offered by practitioners licensed by the State of Minnesota have the right to: (a) expect that a practitioner has met the minimal qualifications of training and has the experience required by state law; (b) examine public records which contain the credentials of the practitioner; (c) obtain a copy of the rules of conduct.

Every client:

- has the right to be informed of and to refuse to participate in any experimental research.
- may expect courteous treatment and to be free from verbal, physical, or sexual abuse by RRC staff.
- has the right to a coordinated transfer of care when there will be a change of providers.
- may assert the client's right(s) without retaliation.
- has the right to choose freely among available mental health professionals and practitioners in the community and to change providers after mental health services have begun within contractual limits of the client's health insurance (if any).

COMMENTS, QUESTIONS, CONCERNS

We value your opinion and strive to provide the best service possible. If you would like to share your comments, questions, or concerns, please contact our Clinical Director, Jenny Holdredge, at 763-754-0903 ext 111 or email jenny@rumrivercounseling.com. You may also complete a confidential satisfaction survey online at our website: www.rumrivercounseling.com.

NOTICE OF PRIVACY PRACTICES (HIPAA)

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. Protecting our patients' privacy has always been important to this practice. A new state and federal law, the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy. At the Rum River Counseling, Inc., we are very careful to keep your health information secure and confidential. This law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. You have the right to see or receive a copy of any of your health information. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W, Room 509F Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Clinical Director, Jenny Holdredge at jenny@rumrivercounseling.com or 763-482-9598.

**PRIMARY CARE PROVIDER NOTIFICATION OF CLINICAL SERVICES
AND CONSENT FOR THE RELEASE OF INFORMATION**

Continuity and coordination between physical and mental health is an important aspect in the delivery of quality health care, as mental and physical disorders can interact to affect an individual's health.

PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH	INTAKE DATE
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PRIMARY CARE PROVIDER INFORMATION

PRIMARY CARE PROVIDER/CLINIC

PHONE	FAX
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ADDRESS	CITY/STATE/ZIP
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MENTAL HEALTH PROVIDER INFORMATION

<p>Dear Primary Care Provider, I am sending this form to notify you that I am currently seeing your patient in a therapeutic setting and to provide our offices with a release of information to facilitate communication and to coordinate services in regards to client care. If further information is desired, please contact me at your convenience. Sincerely,</p> <p>THERAPIST NAME (please print)</p>	<p>MAILING ADDRESS: Rum River Counseling, Inc. 2705 Bunker Lake Blvd. NW Suite 100 Andover, MN 55304</p>
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CLINICAL INFORMATION

REASON FOR REFERRAL OR CARE COORDINATION

DIAGNOSIS	MEDICATIONS
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TREATMENT PLAN(S) OR RECOMMENDATIONS

CONSENT AND RELEASE

I authorize the exchange of information regarding my clinical care needed to coordinate treatment with my primary care physician. I understand that my records are protected under the Federal and specific State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., the provision of treatment upon consent to disclose third party payers) and that this consent expires automatically as described below. Information to be released includes diagnosis, treatment procedures and details of my condition which help to coordinate treatment. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. This release is valid for 1 year after last contact and I may cancel it in writing at any time.

SIGNATURE(S)	DATE
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REFUSE CONSENT AND RELEASE OF INFORMATION

I do NOT authorize information about my physical/mental health treatment to be released or exchanged with my primary care provider.

SIGNATURE(S)	DATE
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MINOR CONSENT & AGREEMENT

"Nobody can go back and start a new beginning, but anyone can start today and make a new ending." ~Maria Robinson, author

MINOR CONSENT

Please check below to indicate the current situation regarding the custody of the minor child:

Parents are married to each other and are the legal parents of the child *(one signature required)*

If parents are divorced and only one signature is present, a copy of the Custody Agreement court documents and a note from a physician supporting counseling based on medical necessity are both required a minimum of 1 business day prior to intake – copies of these documents must be present in the client file (Court documents are also required when a guardian or the State has legal custody)

My ex-partner/spouse and I share legal custody of the child *(both signatures required)*

I am a single parent and have full legal custody of the child *(one signature required)*

The child is in the custody of the State of Minnesota.
County _____ *Court documents are required at intake – a copy must be present in the client file.*

I am a non-parent legal guardian and have full legal custody of the child *(one signature required)* *Legal Guardianship court documents are required at intake – a copy must be present in the client file.*

- ✓ I understand that at least one parent must accompany the minor child to his/her first appointment and any subsequent appointments, until discussed with and agreed upon with the therapist.
- ✓ I understand that Rum River Counseling, Inc. does not give recommendations or do evaluations for child custody or parenting. If this becomes an issue, my child's case may be closed.
- ✓ I hereby grant my permission for my minor child to be treated by Rum River Counseling, Inc. This permission will remain in force until revoked by me.

LEGAL GUARDIAN SIGNATURE

DATE

LEGAL GUARDIAN SIGNATURE

DATE

MINOR AGREEMENT

The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Very often, it is best to see them with parents and other family members; sometimes, they are best seen alone. The therapist will assess which might be best for your child and make recommendations to you. Obviously, the support of all the child's caregivers is essential, as well as their understanding of the basic procedures involved in counseling children.

The general goal of involving children in therapy is to foster their development at all levels. At times, it may seem that a specific behavior is needed, such as to get the child to obey or reveal certain information. Although those objectives may be part of overall development, they may not be the best goals for therapy. Again, the therapist will evaluate and discuss these goals with you.

Because of the role is that of the child's helper, the therapist will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. *Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist.*

The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy may be lost. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is generally being respected, at the same time that parents have access to critical information. This agreement must have the understanding and approval of the parents or other responsible adults and of the child in therapy.

This agreement regarding treatment of minors has provisions for inserting individual details, which can be supplied by both the child and the adults involved. However, it is first important to point out the exceptions to this general agreement. The following circumstances override the general policy that children are entitled to privacy while parents or guardians have a legal right to information.

- Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self or others. In these cases, the therapist is required to make an official report to the appropriate agency and will attempt to involve parents as much as possible.
- Minors may independently enter into therapy and claim the privilege of confidentiality in cases involving abuse or severe neglect, molestation, pregnancy, or communicable diseases, and when they are on active military duty, married, or officially emancipated. They may seek therapy independently for substance abuse, danger to self or others, or a mental disorder, but parents must be involved unless doing so would harm the child.
- Any evaluation, treatment, or reports ordered by, or done for submission to a third party such as a court or a school is not entirely confidential and will be shared with that agency with your specific written permission. Please also note that the therapist does not have control over information once it is released to a third party.

Agreement:

I understand that the normal procedure for discussing issues that are in my child's/children's therapy will be joint sessions including my child/children, the therapist, and me and perhaps other appropriate adults. If I believe there are significant health or safety issues that I need to know about, I will contact the therapist and attempt to arrange a session with my child/children present.

Similarly, when the therapist determines that there are significant issues that should be discussed with parents, every effort will be made to schedule a session involving the parents and the child/children. I understand that if information becomes known to the therapist and has a significant bearing on the child's/children's well-being, the therapist will work with the person providing the information to ensure that both parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively.

I will do my best to ensure that therapy sessions are attended and will not inquire about the content of sessions. If my child prefers/children prefer not to volunteer information about the sessions, I will respect his/her/their right not to disclose details. Basically, unless my child has/children have been abused or is/are a clear danger to self or others, the therapist will normally tell me only the following:

- ✓ *whether sessions are attended*
- ✓ *whether or not my child is/children are generally participating*
- ✓ *whether or not progress is generally being made*

LEGAL GUARDIAN SIGNATURE	DATE
LEGAL GUARDIAN SIGNATURE	DATE
MINOR SIGNATURE	DATE