CONFIDENTIALITY AGREEMENT

As your therapist, my goal is to provide a safe place for you to openly explore personal and relationship issues. I am committed to guarding your right to privacy, within the limits of the law. There are certain situations in which a therapist is *required by law* to reveal information obtained during therapy.

Required disclosure will occur in the following circumstances:

- When a reasonable suspicion of **abuse and/or neglect of a child or vulnerable adult** is present, a report will be made to appropriate protective agencies.
- When you **threaten grave bodily harm to others**, a report will be made to the appropriate authorities, as well as to those you have threatened.
- When you are **suicidal or threaten significant bodily harm to yourself**, I will obtain help from others in your life, such as family members and members of your treatment team, to do what is necessary to keep you safe.
- When a court of law issues a legitimate **court order**.
- When you are in **probation or parole period** or other legal situation that would require disclosure.

Except in the above circumstances, I will release information about you *only if you provide a written request*. Releases of information for families and couples in therapy require the written permission of every participating member in treatment able to execute a waiver. If you require a written request for me to exchange information with another mental health or medical professional relevant to our work together or your work with that individual, I will be happy to provide you with the appropriate form.

In order to provide excellence in clinical services and in accordance with customary professional behavior, I participate in confidential case consultations and supervision. No identifying information is revealed about clients.

Clients under the age of 16 are considered minors and all therapy contracts must be signed by their custodial parent and/or legal guardian. Therefore, custodial parents and/or legal guardians have a right to information shared in the session. Parents and guardians should be aware that exercising this right may be detrimental to the therapeutic process, and so may wish to allow confidentiality between the minor and therapist. In these cases, I will make every effort to foster open communication between parent and minor, and will never disclose information to a parent about a minor without the minor's knowledge.

There are special confidentiality concerns for families and couples in treatment:

- I view the family or couple as a "treatment unit."

- I will not reveal any individual's confidences to others in the treatment unit.

- It is important for you to be aware that secrets shared individually with me are generally not healthy for you or your family/couple relationships. For this reason, if an individual member or subset of the family/couple discloses a confidence that has bearing on other participating members, I will encourage the person(s) to reveal the information to the other member(s). I will provide support for

you in finding ways to disclose the information and will help you deal with the implications of a revelation should it occur. I like to say that I am willing to be a temporary secret "holder" while we work together to find ways to share openly, but I cannot and will not be a long-term secret "keeper".

- ❖ Should you reveal to me a secret that you refuse to disclose to other participating member(s) and that which puts me in a position of compromising my honest relationship with others in the treatment unit, therapy will be terminated.

The signatures below indicate that all participating members understand the nature of confidentiality in therapy as set forth above. Concerns or questions about confidentiality may be discussed at any point in the therapeutic process

_____ _____

Signature Date

INFORMED CONSENT

As your therapist, I have an ethical obligation to help you make an informed decision in seeking treatment to address your concerns. At any time throughout this process, you may ask me to explain why I am requesting information or suggesting a new approach. I will be glad to explain the purpose behind my techniques, and the model from which I am operating. The following outlines possible risks and benefits associated with therapy.

The following is a list of possible risks of participating in therapy.

- Therapy is not an exact science, so there is no guarantee as to therapeutic outcomes. Some people experience no improvements in their situation, and a few may even think things are worse after treatment.
- Effective therapy may result in your experiencing intense and uncomfortable feelings, as well as openly discussing and working toward changing displeasing relationship patterns.
- Therapy can sometimes lead to individual decisions that can be disruptive for yourself and/or your family.
- Some health insurance companies will not cover the cost of therapy.

The following is a list of possible benefits of participating in therapy.

- You may achieve resolution of specific concerns brought to therapy, resulting in greater individual happiness and increased relational harmony.
- You may attain increased understanding of family and personal goals and values.
- You may experience a healing of emotional wounds inflicted past or present.
- The acquisition of healthy coping skills may assist you in relating with others.

The signatures below indicate that the risks and benefits of therapy have been discussed with all participating members. Concerns or questions about these risks and benefits may be discussed at any point in the therapeutic process.

_____ _____

Signature Date

FEE SCHEDULE AND PAYMENT AGREEMENT

All session charges at Lindsey Hoskins & Associates are based on the following fee schedule:

	Dr. Hoskins	Ms. Smith	Ms. Nazareth or Ms. Golojuch
50-minute session	$160.00	$140.00	$120.00
90-minute session	$240.00	$210.00	$180.00
Prepare/Enrich 5-session package	$1000.00	$900.00	$800.00
Surcharge for weekend appointments	$20.00	$20.00	$20.00

Cancellation Policy: When you make an appointment with one of our therapists, that time is specifically reserved for you. For that reason, we require that 24 hours notification in the event of cancellation. If a client is unable to attend a session and does *not* provide 24 hours notice, the full scheduled session fee will be charged for the missed session. This policy applies even if the client arrives to session late or leaves session early.

Payment in full is due at each session. We accept payments via cash, personal check, or credit card. Checks should make checks payable to Lindsey Hoskins & Associates. You may choose any payment option at any appointment. Unless you specify otherwise, we will charge your credit card on file. **A $35 fee applies for all returned checks.**

Regardless of the chosen method of payment, we collect credit card information from all clients to have on file as a backup method of payment.

Credit Card Authorization: Credit card payments will appear on your credit card statement as Lindsey Hoskins & Associates. This authorization will expire upon termination of therapy and when the above named client's account with Lindsey Hoskins & Associates is settled.

Name of Client(s) _____

Cardholder's Name (exactly as it appears) _____

Type of card: □ Visa □ MasterCard □ Discover □ American Express

Credit card number: _____

Expiration date: _____ / _____ DVV Number (3- or 4-digit code) _____

Cardholder's Billing Address _____

_____

Email where receipt should be sent _____

My signature below indicates that I understand the above policies and authorize Lindsey Hoskins & Associates, LLC to charge this credit card in payment for therapy sessions. I understand that this card will be charged automatically, unless I specify that I prefer to pay via cash or check and provide an alternate form of payment at the time of service.

_____ _____

Signature of Cardholder Date

CLIENT DATA FORM

The purpose of this form is to collect basic information about your – a bit about your background, how you found the practice, and what is bringing you to therapy at this time. Each member of the couple/family should fill out his or her own copy of this form. Please answer all questions so that your therapist can learn as much as possible about you! ***All information is confidential.***

Personal Information: Today's Date: _____

Full Name: _____ Address: _____

Date of Birth: _____ / _____ / _____ Age: _____ _____

_____

Contact Information: *For each of the following, please indicate whether it is okay to leave/send a detailed message by checking "yes" or "no" in the corresponding box. Mark the best way to reach you by checking "preferred."*

Cell phone: _____ ☐ Yes ☐ No ☐ Preferred

Home phone: _____ ☐ Yes ☐ No ☐ Preferred

Work phone: _____ ☐ Yes ☐ No ☐ Preferred

E-mail: _____ ☐ Yes ☐ No ☐ Preferred

May we add your email to our practice E-Mailing list? Your privacy is important to use and we will never sell or share your contact information with other parties. ☐ Yes ☐ No

Would you like to communicate with your therapist via text message ***for administrative purposes only? (****For example, to confirm an appointment or let your therapist know that you are running late.) Your therapist will never discuss privileged/confidential information via text message.* ☐ Yes ☐ No

Referral Information: *How did you hear about Lindsey Hoskins & Associates? Knowing this helps us understand the best way to reach other clients like you.*

☐ I was referred by another client. Her/his name is: _____

Is it okay for us to thank this client for referring you, without giving details about your treatment? ☐ Yes ☐ No

☐ I was referred by another mental health provider. Her his name is: _____

Is it okay for us to thank this provider for referring you, without giving details about your treatment? ☐ Yes ☐ No

☐ I found your listing through an online therapist directory (please specify):

☐ Psychology Today ☐ GoodTherapy.org ☐ WeddingWire.com ☐ AAMFT Therapist Locator

☐ Other (please specify): _____

Demographic Information:

Occupation: _____ Employer: _____

Average # hours worked/week: _____ I work on □ Weekdays □ Evenings □ Weekends

Highest level of education: □ High School □ Some college □ Bachelor's Degree □ Graduate Degree

Family Information:

Relationship Status: □ Single □ Dating □ Cohabiting □ Engaged □ Married □ Separated □ Divorced □ Other _____

*Please provide the requested information below **for each person currently living in your household** (even if they are not attending therapy with you):*

Full Name	Gender	Age	Relationship to You

Please provide the requested information below for other family members who are not currently living in your household, but who play a significant role in your life (e.g., partner, child, parent, grandparent):

Full Name	Gender	Age	Relationship to You

Health Information: *Please check "yes" or "no" for each question. If you check "yes," please provide specific information.*

Are you currently taking any prescription medications? ☐ Yes ☐ No

If yes, which medications and why? _____
_____

Are you currently using illegal drugs? ☐ Yes ☐ No

If yes, which drugs and how often? _____
_____

Are you currently drinking excessive amounts of alcohol? ☐ Yes ☐ No

If yes, how many drinks do you usually have per day?
_____

Are there any legal actions pending (criminal or civil)? ☐ Yes ☐ No

If yes, please describe: _____
_____

Are you in any danger of abuse, suicide, or homicide? ☐ Yes ☐ No

If yes, please describe: _____
_____

Have you received therapy in the past? ☐ Yes ☐ No

If yes, please describe type, duration, and reason?
_____
_____

Have you ever received any psychiatric diagnoses? ☐ Yes ☐ No

If yes, what diagnosis, when, and by whom was it given? _____
_____

Do you have any physical health problems or concerns? ☐ Yes ☐ No

If yes, please describe: _____
_____
_____

Therapy Information:

What type of therapy are you seeking? Please select all that apply.

☐ Individual ☐ Couple ☐ Family ☐ Group

Please provide a brief description of the issue(s) for which you are seeking therapy, and why you are seeking therapy at this time.

Please list your initial goal(s) for therapy:

1. _____

2. _____

3. _____

Emergency Contacts: Please provide the name and contact information for two people you would want me to contact in the event of an emergency:

Name: _____ Name: _____

Relationship to you: _____ Relationship to you: _____

Daytime phone: _____ Daytime phone: _____

Evening phone: _____ Evening phone: _____