Safety-Net Therapeutics

3008 Sudbury Drive
Kettering, Ohio 45420

"In the multitude of counsel, there is safety"

Tel: (937) 310-1269
Fax: (937) 310-1199

CLIENT INFORMATION FORM

Today's Date ________________________________ Birthdate ______________________________________

Client Name _________________________________ Gender ____

Age ____ Ethnicity ______________________________________

Address _____________________________________ City, State, Zip ________________________________

Home Phone __________________________________ Cell Phone _____________________________________

Email _______________________________________ Relationship Status ____________________________

Social Security Number ________________________ Primary Care Physician _________________________

Employer ____________________________________Title ____

Work Address ________________________________ Phone Number __________________________________

EMERGENCY CONTACT

Name _______________________________________ Relationship:_________________________________

Address _____________________________________ Phone _______________________________________

City, State, Zip ________________________________ Cell Phone Number ____________________________

Birthdate ______________________________________

CHILDREN: NAMES AND BIRTHDATES

____ ____

____ ____

Referred by ____

Person responsible for this account ____

Can confidential messages (i.e. appointment reminders) be left on any of the folllowing?

On home voicemail?	YES ___________	NO ___________
At work?	YES ___________	NO ___________
On your cell?	YES ___________	NO ___________
With spouse/significant other?	YES ___________	NO ___________

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INSURANCE INFORMATION FORM	
	PRIMARY INSURANCE
NAME OF INSURANCE:	
Policy Number:	Group Number:
Name of Policy Holder:	
Policy Holder's Address:	
Policy Holder's Phone:	Policy Holder's Date of Birth:
Employer:	
Employer Address:	Employer Phone:
Name of Client:	Relation to Policy Holder: Self ____ Spouse ____ Child ____ Other ____
***SECONDARY INSURANCE**	
NAME OF INSURANCE:	
Policy Number:	Group Number:
Name of Policy Holder:	
Policy Holder's Social Security Number:	
Policy Holder's Address:	
Home Phone:	Policy Holder's Date of Birth:
Employer:	
Employer Address:	Employer Phone:
Client's Name:	Relation to Policy Holder: Self _____ Spouse _____ Child _____ Other
Did you call your insurance company and receive an authorization number? Yes _____ No _____	
If yes, what is the authorization number?	

***NOTE**: Safety-Net Therapeutics does not submit claims for Secondary Insurance! We will however provide you with a receipt to personally submit for reimbursement. Any fees accrued and not covered by the Primary Insurance are the responsibility of the client and failure to pay may result in delayed services.

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GENERAL RULES AND REGULATIONS

In order to maintain a safe and welcoming environment for our Clients, Safety-Net Therapeutics requires all visitors to comply with the following General Rules and Regulations.

The following are NOT allowed at Safety-Net Therapeutics:

- Engaging in conduct that disrupts or interferes with normal operation of Safety-Net Therapeutics, or that disturbs staff or other individuals that are obtaining services. Such conduct includes, but is not limited to:
    - Harassing or threatening behavior.
    - Using obscene or abusive language or gestures.
    - Making unreasonable noise, including loud talking on a cell phone or otherwise.
- Engaging in sexual conduct or lewd behavior.
- Having a knife, gun, or any other weapon.
- Smoking (Except in designating areas)
- Eating or drinking (Except in designated areas)
- Using alcohol or illegal drugs.
- Soliciting, petitioning, or canvassing.
- Bringing in an animal, unless it is assisting a person with a disability accompanied with Dr. order.
- Damaging, defacing, or misusing any Safety-Net Therapeutics materials or property.
- Engaging in any activity in violation of federal, state, local, or other applicable law or Safety-Net Therapeutics' policies.

Please also be aware that:

- Safety-Net Therapeutics is not responsible for personal items that are lost, stolen, or damaged on Safety-Net Therapeutics' premises.
- Safety-Net Therapeutics' staff can inspect any of your property when you come in or leave.
- You must wear clothing and shoes at Safety-Net Therapeutics.
- Some records cannot be printed because of the confidential nature, but your counselor will gladly review your records with you at any time
- Safety-Net Therapeutics is not responsible for children who are left unattended on Safety-Net Therapeutics premises; please see Safety-Net Therapeutics' "Unattended Children Policy."
- Safety-Net Therapeutics staff can ask visitors to show their ID at any time.
- All Visitors must check in and out at the front desk
- Photography and recording are not allowed on Safety-Net Therapeutics premises without prior permission.
- Visitors with disabilities may ask Safety-Net Therapeutics staff for reasonable accommodations.
- Visitors who do not follow the Safety-Net Therapeutics Rules and Regulations can be asked to leave at any time.

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UNATTENDED CHILDREN POLICY

Safety-Net Therapeutics is dedicated to providing a welcoming environment. Safety-Net Therapeutics staff are available to assist and support children with their use of resources. However, Safety-Net Therapeutics is not responsible for children who are left unattended on Safety-Net Therapeutics premises. Unattended children are children of any age who are apparently unaccompanied by a parent, guardian, and/or responsible caregiver at Safety-Net Therapeutics

Parents, guardians and/or caregivers are solely responsible for the safety and behavior of their children. They are advised that children are expected to comply with Safety-Net Therapeutics' "General Rules and Regulations" and a child who violates those rules may be asked to leave Safety-Net Therapeutics premise.

Exposure to litigation: Safety-Net Therapeutics has a legal duty to create a safe environment to protect against reasonably foreseeable harm. Although the law recognizes that it is not possible to ensure perfect safety, Safety-Net Therapeutics does have the duty to supervise its premises adequately so that people lawfully using the Safety-Net Therapeutics are not unreasonably exposed to danger.

Problems can arise when parents confuse the feeling of safety in a Counseling practice with the objective reality of the Counseling practice as a public place. A Counseling Practice cannot guarantee absolute safety to everyone using the facility, nor do they want to deny access to Clients who want to use it in a lawful manner.

Children must be supervised while on Safety-Net Therapeutics property and in the Safety-Net Therapeutics building. Children under (10) must have a responsible caregiver 16 or older on the premises, and children 7 or under must be accompanied at all times.

An unattended child is a child of any age who is apparently unaccompanied by an adult. Parents, guardians, and caregivers may not leave children alone or in the care of other children who are unable or unwilling to provide adequate care. Supervising adults must be close at hand.

As in all public places, "stranger danger" is a real concern. Safety-Net Therapeutics staff cannot prevent children from interacting with or leaving with persons who are not the appropriate chaperone.

Staff may refer to Montgomery County Children and Family Services for those children who are left unattended at Safety-Net Therapeutics and whose basic needs for food, rest, parental supervision or attention are not being fulfilled.

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If Safety-Net Therapeutics is closing, at regular time or in an emergency situation, and a parent or guardian of a child cannot be located in the building, the City of Kettering or Dayton Police Department most likely will be called.

Safety-Net Therapeutics is not responsible for any consequences of parents forfeiting their responsibilities.

Safety-Net Therapeutics reserves the right to amend these regulations from time to time.

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CLIENT AGREEMENT AND THERAPEUTIC POLICES

Introduction:
This agreement is intended to provide clients with important information regarding my professional services and business policies. This consent form will provide a clear framework for our work together and will facilitate our therapeutic relationship. Any questions or concerns regarding the contents of this agreement should be discussed with me **prior to signing it**.

Part I: Practice and Therapist

Information Professional Practice Orientation:
As a professional practice we provide individual therapy for adults, adolescents, and children and we also provide group therapy clients in need of these services. Addiction, depression, anxiety, post-traumatic stress disorder, self-mutilation, addictions, behavioral issues, self-confidence building, and relationship improvements are some of the many issues that we can treat at our practice.

A therapist's style of treatment is best rooted in the individual counselor's experience and training. As a practice comprised of many counselors, each counselor will utilize their own style and approach to treatment. Most of our counselors use an integrative approach, which allows for a more individualized treatment plan. Possible approaches may include but are not limited to Cognitive Behavioral Therapy (CBT), Solution-Focused Brief Therapy, Choice/Reality Therapy, Client-Centered and Mindfulness Based Stress Reduction (MBSR). The office is a great setting for therapy to take place with an eclectic theme that provides a comfortable and peaceful environment for healing to begin.

Educational/ Training Background:
Our practice is comprised of LICD's and CDCA's that are approved by the State of Ohio.

Client's Initial's

(Continued on Next Page…)

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Part II: Client(s) Rights

1. You have the right to ask questions about any procedures used during therapy; if you wish, the therapist will explain their approach and methods to you.

2. You have the right to decide not to receive therapeutic assistance from any counselor within the practice; if you wish, the therapist will provide you with the names of other qualified professionals whose services you might prefer.

3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those *already* accrued. We ask you contact us by phone or in person before you make such a decision without prior discussion.

4. You have the right to expect that the practice and therapist will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, all of which would greatly compromise our work together.

5. Therapy involves a partnership between therapist and client. As your therapist, I will contribute knowledge, skills and a willingness to do my best.

Client's Initial's

Associated Risk of Therapy:
Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. The issues presented by you may result in unintended outcomes, including changes in personal relationships. During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Please address any concerns you have regarding your progress in therapy with your therapist.

Client's Initial's

Appointments:
Your appointment time is reserved especially for you. Therapy sessions are normally 60 minutes. Cancellations must be made 24 hours in advance; otherwise, you are responsible for a $80 fee. Regular attendance is recommended to insure continuity and to enhance the effectiveness of the therapy. For more information on appointments and associated fees, please see the Appointments and Professional Fees section of the Informed Consent for Therapy Services policy.

(Continued on Next Page…)

E-Mail, Cell Phones, Computers and Faxes:
It is very important to be aware that computers, E-mail and cell phone communication can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. E-mails in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, the emails sent by myself are not encrypted. Faxes can easily be sent erroneously to the wrong address. We will only use computers that are equipped with a firewall, a virus protection and a password.

Records and Administrative Services:
Your therapist may take notes during session and will also produce other notes and records regarding treatment. These notes constitute their clinical and business records, which by law, they are required to maintain. Should you request a copy of my records, such a request must be made in writing. The practice reserves the right under Ohio law, to provide you with a treatment summary in lieu of actual records when deemed clinically appropriate by the therapist. We also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. We will maintain client's records for seven years following termination of therapy. If a client is a minor**,** records will be maintained for ten years after minor's eighteenth birthday. However, after 7-10 years, your records may be destroyed in a manner that preserves your confidentiality.

Professional Fees and Payments:
We will discuss and establish our fee at the outset of treatment, and any fee change will be negotiated in good faith. Payment is expected at the beginning of each session unless we have agreed otherwise. ***Balances more than 120 days overdue may be subject to collection through the use of a collection agency.*** However, we will first attempt to make other arrangements with you as needed. In general, it is important to discuss with the practice any issues that arise in connection with our financial arrangements, so that they do not hinder your working relationship with your therapist.

Client's Initial's

Please read the following statements and initial:

- ***A 24 - hour notice is required for the cancellation of a scheduled session. If I do not meet this requirement, I agree to pay a $80 missed appointment fee. I understand that this will be my responsibility, not that of the third-party payer.***

Client's Initial's

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- ***I understand that Medicaid and any other Medicaid HMO client will not be charged a cancellation fee but is subject to the provider and termination of services after three failures to comply to the previously stated cancellation agreement.***

Client's Initial's

- ***I understand that the therapist has the right to seek legal recourse to recoup any unpaidbalance. In pursuing these measures, the therapist will only disclose biographical information and the amount owed in order to ensure confidentiality.***

Client's Initial's

CONSENT FOR SERVICES:

Thank you for reviewing this information and please feel free to discuss any of this information with us. We/Our signature(s) on this disclosure statement indicates I/We have read and understood the conditions of the consultation services outlined. I/We have had the opportunity to clarify any questions and agree to the terms described above before receiving services. I/We have been provided with a copy of this disclosure statement.

Client Signature____ Date_______________

Client Signature____ Date_______________

Therapist Signature____ Date_______________

Supervisor Signature____ Date_______________

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INFORMED CONSENT FOR THERAPY SERVICES

Service Agreement:
Welcome to our practice. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Psychological Services:
Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-3 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

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Appointments:
Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the amount of $80 in the form of a cancellation fee, unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Professional Fees:
Please read the fee schedule below for information regarding standard fees for Self-Pay, special services and other miscellaneous fees you may encounter during your time as a client of our practice.

Session Fees/Rates

- For an initial intake session (60-minutes), the fee is $150.00
- For an individual session that in 45-minutes in length is $130.00
- Services rendered by a Counselor in Training (CT)/Intern are $50.00

Miscellaneous Services

- Consultations to schools, physicians, other professionals, etc., will be billed at our usual hourly rate of $130.00 per hour, and may be subject to travel costs.
- Any written reports, this includes substance abuse evaluations, are $120.00. Payment is due at the time you receive the report.
- Missed Appointments or Late Cancellations are costly to the therapist and deny other individuals the opportunity to use that time. Unless a true emergency exists, we require that all cancellation be made at least 24-hours in advance. If you miss an appointment or do not cancel as agreed upon prior in these agreements, you will be charged a $80.00 cancellation fee. Clients with **Medicaid or associated plans** will not be charged but may be subject to a change in provider or termination of services after failure to comply for ***three sessions***.
- Payments must be made at the time of service. Any checks returned to my office are subject to an additional fee of up to $35.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-V. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable.). Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount, which must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

Professional Records:
I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health

health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

Confidentiality:
My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

Parents & Minors:
While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

Contacting Me:
I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on the confidential voice mail for our office and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact Crisis Care (937-224-4646), 2) go to your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

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Other Rights:
If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

Consent to Psychotherapy:
Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

____
Signature of Patient or Personal Representative

____
Printed Name of Patient or Personal Representative

Date ____________________________________

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NOTICE OF COURT COSTS

Safety-Net Therapeutics values and respects the judicial system and how we can play a useful role in the legal process. Due to respecting this process and the time it requires to be prepare, Safety-Net Therapeutics, LLC charges a fee to appear in court by subpoena. Therefore, we wish to have a clear understanding of the expectations and fees:

A. Court appearance is by subpoena only.

B. The fee for court appearances is:

1. $1600.00 per full day ($200.00 per hour).
2. In addition to the court appearance or testimony, there is a charge for three (3) hours preparation for testifying - $600.00.
3. In order to ensure the availability of the Therapist, a retainer of the full estimated amount will be due upon receipt of the subpoena. In the event of cancellation of the court appearance, the deposit will be forfeited unless Safety-Net Therapeutics, LLC receives a cancellation notice at least 72 hours (3 business days) prior to the scheduled court appearance. The $600 preparation fee will be forfeited no matter when the appearance is canceled.
4. The hourly fee, $200.00 is per therapist requested by subpoena. These fees are in effect unless previous contract obligations dictate otherwise.

My signature below indicates I understand and accept these policies and fees that will be charged should there be a subpoena.

______________________________ ______________________
Client Signature Date

______________________________ ______________________
Counselor's Signature Date

______________________________ ______________________
Supervisor's Signature Date

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RELEASE OF INFORMATION AUTHORIZATION FORM

Client Name:____Date of Birth: __________________________

I authorize Safety-Net Therapeutics and/or its administrative and clinical staff to **release** and/or **receive** the following information:

- ☐ Clinical Record (such as: information regarding reasons for seeking therapy, a description of the impact of your problem, diagnosis, treatment goals, progress on treatment goals, medical/social/treatment history, past treatment records, testing results, etc.)
- ☐ Letters (written at your request)
- ☐ Reports (written at your request)
- ☐ Phone Consultation (with your Primary Care Physician, school, lawyer, probation/parole officer, social worker, etc.)

This information should only be released to or received from:
Name:__________________________________ Address:____
Phone Number:___________________________Fax Number: _____________________________________

I am requesting my counselor/therapist/psychologist to release information for the following reasons (at the request of the individual" is all that is required if you are my client/patient and you do not desire to state a specific purpose.): ____

____

This authorization shall remain in effect until______or 180 days from the date of my signature below.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my counselor/therapist/psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of your information and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA).

____ ____________________
(Signature of Patient or Legal Guardian) (Date)

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CONFIDENTIALITY AND COUPLES CONSENT

Confidentiality and Couples:

The information individuals reveal in a counseling session is confidential, with a few exceptions determined by law (see my Professional Disclosure and Treatment Consent Form for details). How does this rule of confidentiality apply to couples' therapy in which two people are involved?

*Three things are important to kno*w:

1. Confidentiality is held jointly by both partners. Unless one of the legally prescribed exceptions apply, I cannot divulge any information to an outside party unless both of you consent.
2. While I am bound by confidentiality as your therapist, I have no control over what your partner might reveal to others outside of the session. Considering this, I strongly encourage each of you to make a commitment to respect each other's confidentiality (no matter how acrimonious your relationship may be now or in the future) so that each can participate freely and sincerely in the counseling process.
3. At times during the course of therapy, I might meet with one of you individually. You should assume that any information you convey to me individually is not necessarily held in strict confidence from your partner. One reason for this is that I cannot always be relied upon to remember who told me what, and/or when. It does not mean that I will be telling your partner details about what you said. Rather it is my philosophy to not be in the middle and to encourage you to communicate to each other what is important to the counseling process or the integrity of your relationship. I will likely encourage you to convey that to your partner in a subsequent session. This policy also applies to any phone calls, e-mails, or letters received by me from one of you containing content relevant to therapy. If you contact me individually, please inform your partner and know that I will need to let them know you contacted me in the next session. This is important to maintain openness and trust in the counseling process. If you have any concerns about this policy, please feel free to discuss it with me.

By signing below, you indicate you understand and agree to this policy.

Client's Signature____ Date______________

Partner's Signature____ Date______________

Clinician's Signature____ Date_______________