

IMPORTANT INFORMATION ABOUT CONFIDENTIALITY

Many people believe that everything that is said in therapy is always kept confidential by their therapist. I am committed to keeping what you tell me private and confidential. However, some laws and careful professional practices may require me to tell others what you have said to me. Please carefully read and initial each of the following statements about some of the situations in which I cannot promise to protect your confidentiality. Changes in the laws and other circumstances out of my control may add situations to the list below that may affect your privacy. Please ask questions about what you read and only initial or sign when you are satisfied you understand the answers.

_____ I understand that my therapist is required by law to report suspected or actual incidents of abuse or neglect of children, the elderly or others unable to care for themselves.

_____ I understand that the law permits my therapist to notify law enforcement officials or medical professionals if she believes I am dangerously close to harming myself or others.

_____ My initial here gives my therapist permission to notify the following persons in cases of emergency or if he believes I am dangerously close to hurting myself or others. I understand that my therapist may disclose his concerns to the following persons in order to get me the best help possible.

Name: _____ Phone: _____

Name: _____ Phone: _____

_____ I understand my therapist is concerned about the life and safety of all persons and that he may choose to notify any person he perceives I am dangerously close to harming (in addition to notifying law enforcement officials) in

order to safeguard my safety and the safety of others.

_____ I understand my therapist may be required to turn over my mental health records to an attorney or a judge if I am involved in a legal case such as child custody, civil litigation or criminal proceedings (please refer to the attach Policy for Legal Matters).

_____ I understand that if I choose to use insurance to pay for therapy I am waving my rights to confidentiality to the extent requested by the insurance company.

_____ I understand I am responsible for paying a fee of _____ for each _____ minute therapy session and that I will pay, by check or cash, at the time of service rather than accumulating a balance.

_____ I understand I will be charged and expected to pay for missed (no show) or late cancelled (with less than 24 hours notice) appointments and that my insurance will not pay for missed or late canceled appointments.

_____ I understand my therapist may consult with other professionals concerning my case in order to assure high quality service to me. I understand that she will protect my identity and confidentiality (within the limits listed above) when consulting with other professionals on my behalf.

My signature below means I have read this form, been given opportunity to ask questions and have received answers to my questions that I understand. My signature also means I am making a voluntary, informed choice to enter a counseling/therapy relationship with Jim Wayland, Ph.D., LPC, LCDC

Signature _____ Date: _____