GroundWork
COUNSELING
400 South Orlando Avenue, Suite 206
Maitland, Florida 32751
407.378.3000

Client Informed Consent

Welcome to Groundwork Counseling, LLC. Prior to your first appointment, we invite you to review the following important information regarding our services and practices. Please note any questions that you have while reading through the following information so that we may discuss them further. Signing this form will represent an agreement between yourself and Groundwork Counseling, and acknowledge that you feel adequately informed regarding the services and support you will receive during the counseling process.

Therapy, Counseling & Coaching Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient, and the particular problems you bring forward. There are many different methods your counselor may use to treat the problems that you want to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we discuss both during our sessions and at home.

Therapy, counseling, and coaching can have benefits and risks. Since therapy often involves discussing difficult or challenging aspects of your life or past, you may find yourself (or your child) experiencing intense emotions while in therapy. On the other hand, therapy, counseling and coaching has shown to be significantly beneficial to those who participate in it. Therapy can often assist individuals to find solutions to problems, improve self-image, reduce negative feelings, and improve relationship quality. There are no guarantees of what you will experience.

If at any time during our counseling relationship you would like more information regarding therapeutic interventions, education, or general information please do not hesitate to ask.

Assessment & Sessions

Your first few sessions (or your child's first sessions), will include an evaluation and assessment of your needs (or your child's needs). After several sessions, your counselor will be able to offer some initial impressions and will work with you to establish therapeutic goals. Each session is scheduled for 50 minutes in length, unless the client (or parent) has requested a 75-minute session (at an additional fee). Frequency of appointments will be mutually agreed upon as part of your plan of care.

Cancelation Policy

Once an appointment is scheduled all clients are required to pay for that appointment at the fee set for the length or purpose of the appointment unless 24-hour notice is provided. Cancellations with less than 24 hours notice will be charged the full session fee. Excessive missing of appointments, whether paid or unpaid, will result in a reevaluation of our therapeutic relationship and your continuation in therapy. Your counselor reserves the right to terminate the counseling relationship in the event that 2 consecutive appointments are missed without notification of cancelation. Please note that consistency in counseling, and attending each session will provide you with the optimum potential to benefit from your therapeutic experience.

Service Fees (For All Counseling Appointments):

50 Minute Session: $100 - $175 (dependent upon provider)

**Sliding Scale Available Based On Family Income and Availability*

In addition to weekly appointments, your counselor charges this amount for other professional services you may request in addition to counseling. Other services include report writing, telephone conversations lasting longer than 15 minutes, exposure therapy, or preparation of records or treatment summaries. You will be expected to pay for your counselor's time even if your counselor is called to testify by another party. Because of the difficulty of legal involvement, your counselor charges $500 per hour for preparation and attendance at any legal proceeding.
If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, GroundWork Counseling has the option of using legal means to secure payment. This may involve hiring a collection agency or through small claims court. If such legal action is necessary, the costs will be included in the claim. In most collection situations, the only information GroundWork Counseling will release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

Payment
Cash, checks, and all credit cards are accepted. **A credit card must be on-file with release to auto-bill for your appointment if an appointment is missed without 24 hours notice.** Also, auto-billing can be utilized for each appointment if it is more convenient for you.

Insurance
GroundWork Counseling does not reimburse through insurance. You may attempt third part reimbursement; your counselor can supply a bill for you to submit to your insurance provider, however, we do not guarantee reimbursement. Please be aware that if you request a summary or bill to submit to your insurance provider, it is likely that your insurance company will require your therapist to provide them with a clinical diagnosis, and may request additional clinical information such as treatment plans or summaries.

Contacting Your Therapist & Office Hours
GroundWork Counselors are not often immediately available by telephone. While GroundWork Counseling maintains office hours (by appointment only), your counselor is often with other clients and unable to answer the phone. When your counselor is unavailable, your call will be answered by our answering service, or your counselor's voicemail, which your counselor monitors frequently. Counselors will make every effort to return your call within one business day, with the exception of weekends and holidays. If you do not hear back from us in that time frame, please call back as it may mean that the voicemail box did not retain your message. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach your counselor and feel that you can't wait for your therapist to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If your counselor will be unavailable for an extended time, they will provide you with the name of a colleague to contact, if necessary.

Contact Via Email & Text
Information contained in email and text messages may be privileged and confidential. However, there is some risk that any information that may be contained in such email or text message may be disclosed to, or intercepted by, unauthorized third parties. Please be aware that email and text communication can be intercepted in transmission or misdirected.
Initialing here _____ indicates that you acknowledge and accept the possible risks associated with email and text communication, and consent to use these methods of communication with your counselor.

Qualifications
At Groundwork Counseling, we offer counseling services from Licensed Mental Heath Counselors, Licensed Marriage and Family Therapists, Licensed Social Workers, Registered Mental Health Counseling Interns, Registered Marriage and Family Interns, and Registered Social Work Interns. Licensed Mental Health Counselors (LMHC), Licensed Marriage and Family Therapists (LMFT), and Licensed Clinical Social Workers (LCSW) hold a master's degree in Clinical Mental Heath Counseling, Marriage and Family Therapy, or Clinical Social Work; these counselors are fully licensed with the state of Florida and hold an active Florida license – these license numbers are available by request.
Registered Mental Health Counseling Interns, Registered Marriage and Family Therapist Interns, and Social Work Interns hold a master's degree in clinical mental heath counseling, marriage and family counseling, or social work, and are registered in the state of Florida as a counseling intern seeking state licensure and currently practice under the supervision of a licensed counselor; registration numbers and supervisor contact information is available by request.

Professional Records
The laws and standards of our profession require that counselors keep treatment records of each session. This information can be requested in writing and will be provided to clients either in full or in summary. This information is maintained in clinical language and is subject to misinterpretation and as a result could be upsetting. If your counselor believes this information is subject to high levels of misinterpretation your counselor may offer to review the records with you during a scheduled session. Because these records contain sensitive information we strongly suggest patients reviewing them with your mental health provider.
GroundWork Counseling utilizes a "paperless" approach to record keeping. Your files will be stored on a HIPPA approved, secured and password protected cloud-based software. Any hardcopy files will either be filed in accordance with HIPPA / ACA guidelines or scanned into the database and shredded.

Minors
If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. GroundWork requests that parents to not request to examine minors records, or request a summary without the minor's consent.

Confidentiality
In general, law protects the privacy of all communications between a patient and counselor. Your counselor can only release information with your written permission. But there are a few exceptions:
In most legal proceedings, you have the right to prevent your counselor from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order your counselors testimony if he/she determines that the issues demand it.
There are some situations in which your counselor is legally obligated to take action to protect others from harm, even if some information about a patient's treatment must be revealed. For example, if your counselor believes that a child, elderly person, or disabled person is being abused, they are required to file a report with the appropriate state agency.
If your counselor believes that a patient is threatening serious bodily harm to another, they are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, your counselor may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations rarely occur in the scope of our practice. If a similar situation occurs, your counselor will make every effort to fully discuss it with you before taking any action.
Your counselor may occasionally find it helpful to consult other professionals about a case. During a consultation, your counselor will make every effort to avoid revealing identity of the patient. The consultant is also legally bound to keep the information confidential. If you don't object, your counselor will not tell you about these consultations unless they feel that it is important to your work together.
While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you and your counselor discuss any questions or concerns that you may have during your initial meeting. Your counselor will be happy to discuss these topics with you if you have questions, but formal legal advice may be needed because the laws governing confidentiality are quite complex and we are not attorneys.

Your signature below indicates that you have read the information in this document and agree to abide by its terms.

_____ _____
Client / Legal Guardian Date

_____ _____
Counselor Date

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Notice of Privacy Practices

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU IS PROTECTED AND MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

I. Confidentiality

As a rule, I will not disclose information about you, or the fact that you are my client, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, a diagnosis if applicable, functional status, symptoms, prognosis and progress, and any assessment tools administered or obtained. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing a general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. "Limits of Confidentiality"

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, I require that you sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together. I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· **Emergency:** If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

· **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Florida law to report the matter immediately to the Abuse Hotline at 1-800-96-ABUSE.

· **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Florida law to immediately make a report and provide relevant information to the Abuse Hotline at 1-800-96-ABUSE.

· **Court Proceedings:** If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you. If there is a criminal or civil case being pursued or considered I ask that you advise me as this makes records more subject to being requested and may have an effect on your response to therapeutic services provided.

· **Serious Risk to Health or Safety to Self:** Under Florida law, if I am engaged in my professional duties and you indicate an intent and verbalize means to bring harm to yourself I am required to take steps to ensure your safety. If you indicate an intent and verbalize means to complete or attempt a suicidal gesture I am required to take steps to ensure your safety. For both of these instances voluntary or involuntary hospitalization will be utilized and Baker Act procedures initiated to minimize the likelihood that you will be able to bring harm or fatal injury upon yourself.

· **Serious Risk to Heath or Safety to Others:** Under Florida law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to inform the third, or threatened party. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.

·**Workers Compensation:** If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
· **Records of Minors:** Florida law limits the confidentiality of the records of minors. For example, parents may not be denied access to their child's records. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors. Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

II. Patient's Rights and Providers Duties:
· **Right to request restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request but will do my best to disclose the minimum necessary information. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.
·**Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.
· **Right to an Accounting of Disclosures:** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice).
· **Right to Inspect and Copy:** In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.
· **Right to Amend:** If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.
· **Right to a Copy of This Notice:** You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the change notice effective for medical information I already have about you as well as any information I receive in the future. If there are changes a new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.
·**Complaints:** If you believe your privacy rights have been violated, you may file a complaint. To do this, you may submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services or visit their website at www.hhs.gov.

Patient's Acknowledgment of
Receipt of Notice of Privacy Practices

Your signature indicates that you have been provided a copy of the Notice of Privacy Practices of GroundWork Counseling LLC, that we have discussed these policies, and you understand that you may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

Signature: _____
Printed Name: _____
Date: _____

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Credit Card Authorization Form

GROUNDWORK COUNSELING REQUIRES ALL ACTIVE CLIENTS TO HAVE A CREDIT CARD ON FILE

Cardholder Name: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____

Charge this card automatically for appointments? (Please circle one of the following)

YES (Always, for all appointments)

SOMETIMES (If I do not have a check or cash)

NO (I will be paying with cash or check – only use this card for missed appointments without 24hr notice)

I authorize GroundWork Counseling LLC to charge the agreed service charge to my credit card provided herein. I understand my card will be charged the full service fee for missed appointments if 24 hours notice is not given. I agree that I will pay for this service in accordance with the issuing bank cardholder agreement.

Cardholder – Print Name, Sign and Date Below:

Name: _____

Signed: _____

Dated: _____

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Child Intake Form

Child's Name: _____
Date Of Birth: _____ Current Age:_____

Person filling out this form: _____ Relationship to child: _____

Today's Date: _____

How did you hear about us / referred by:
__Google Search __Pediatrician __Psychiatrist __School __Word Of Mouth/Friend __Other

Address:_____
Home Phone:_____ May I contact you at your home? YES NO
Cell Phone: _____ May I contact your cell phone? YES NO
E-mail Address:_____ May I contact you via email? YES NO

Family

Biological Mom:_____ DOB:_____

Biological Dad:_____ DOB:_____

(if applicable) ___/___/___Married ___/___/___Separated ___/___/___Divorced

Is Your Child Adopted? YES NO

Child's Age At Adoption: _____ Date Of Adoption: _____

Adoptive Parents:

Mom: _____ DOB: _____ Date became adoptive parent: _____

Dad: _____ DOB:_____ Date became adoptive parent: _____

(if applicable) ___/___/___Married ___/___/___Separated ___/___/___Divorced

Siblings:

Name: _____ Age:____ Name: _____ Age:____

Name: _____ Age:____ Name: _____ Age:____

People in household, if different from above:

_____

_____

If separated or divorced, visitation schedule:

_____

_____

Does father work outside of the home? __Y, __N; Occupation: _____ Hours:_____

Father's highest level of education: _____

Does mother work outside of the home? __Y, __N; Occupation: _____ Hours:_____

Mother's highest level of education: _____

Does either parent have legal issues? _____

Does the child have legal issues? _____

Does your family have a specific spiritual belief or religion? _____

Education

School:_____ Grade: _____

Length of time enrolled in current school _____ Previous school _____

How does your child do in school academically? _____

How does your child do in school behaviorally?_____

Does your child have a learning disability? __Y, __N, __Maybe

Specify: _____

Mental Heath & Medical History

Has Your Child Previously Received Counseling? YES NO

Previous Therapist:_____ Child's Age _____ Duration _____

Previous counseling experience (please include concerns addressed in previous counseling, results, etc.)

_____

_____

Does your child have a mental health diagnosis? __Y, __N

Specify: _____

Primary Care Physician: _____ Phone:_____ Last seen on: _____

(If applicable) Psychiatrist: _____ Phone:_____ Last seen on: _____

Current medications: (Include dosage and frequency):

_____

_____

List any medical conditions or history (Ex: Strep Infections, Surgeries, etc.)

_____

_____

Allergies: _____

Reached developmental milestones: __On time, __Early, __Late

During Pregnancy, Did Mother Use:

Cigarettes YES NO | Alcohol YES NO | Drugs YES NO | Experience Extreme Stress YES NO

If YES to above, please specify frequency, amounts, and duration: _____

List any history of mental illness or addiction in immediate or extended family (Ex: Anxiety, OCD, Depression, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

_____

_____

_____

_____

Trauma History

Has your child been verbally abused? __Y, __N, __Suspected Specify: _____

Has your child been physically abused? __Y, __N, __Suspected Specify: _____

Has your child been sexually abused? __Y, __N, __Suspected Specify: _____

Has your child witnessed domestic violence? __Y, __N, __Suspected Specify: _____

Has your child witnessed substance abuse? __Y, __N, __Suspected Specify: _____

In the first two years, did your child experience:

__Separation from mother, __Out of home care, __Disruption in bonding, __Depression of mother, __Abuse, __Neglect, __Chronic pain, __Chronic Illness, __Parental Stress

If yes, please specify: _____

Has your child experienced any significant loss? If yes, explain: (please include dates)

_____

_____

How many times has your child moved homes? _____

How is your child disciplined? _____

Has your child experienced any significant life changes in the last year? YES NO

If yes, explain: (please include dates)

_____

_____

What do you view as your child's strengths and positive traits?

_____

_____

_____

_____

What are your child's hobbies / interests / supportive activities?

_____

_____

Who are supportive people in your child's life?

_____

_____

_____

How would you describe your child's personality?

_____

_____

_____

Choose characteristics that apply to your child:

____ Anxious	____ Mature	____ Flexible
____ Obsessive	____ Immature	____ Bored
____ Lonely	____ Easily influenced	____ Hot Tempered
____ Intelligent	____ Enthusiastic	____ Independent
____ Inattentive	____ Self-Conscious	____ Gets along well w/ others
____ Aggressive	____ Pessimistic	____ Forgetful
____ Messy	____ Optimistic	____ Loving
____ Resourceful	____ Bully	____ Detached / Isolated
____ Gentle	____ Victim	____ Clumsy
____ Assertive	____ Energetic	____ Humorous
____ Humorous	____ Shy	____ Stubborn
____ Rigid	____ Fearful	____ Fidgety
____ Compulsive	____ Sensitive	____ Resilient
____ Unusual	____ Neat	____ Sensitive
____ Friendly	____ Underactive	____ Fidgety
____ Irritable	____ Overactive	____ Considerate
____ Hyper	____ Impulsive	____ Insecure
____ Lazy	____ Cries easily (emotional)	____ Helpful
____ Nervous	____ Self-conscious	____ Loving
____ Perfectionistic	____ Prefers to be alone	____ Jealous
____ Happy	____ Sad	____ Distressed

Circumstances leading to seeking therapeutic support:

_____

_____

_____

Duration of current challenges (if known):

_____

Is your child sexually active? YES NO MAYBE

Does your child engage in self-injurious behaviors (cutting, etc.)? YES NO

If yes, please explain (please include when behavior began, frequency, and severity)

_____

Does your child a history of, or current suicidal thoughts or behaviors? YES NO

If yes, please explain

_____

_____

_____

Current Symptoms (*Please circle those that apply)*

Anger	Health Anxiety
Anxiety (general)	Lack of Motivation
Anxiety (specific phobia)	Low Self-Esteem
Avoidant Behaviors	Lack of Emotional Regulation
Behavioral Issues (acting out)	Stealing
Depression	Controlling
Disordered Eating	Defiance
Emotional Distress	Drug or Alcohol Use
Family Relationship Issues	Lethargy
Compulsions / Ritualistic Behaviors	Lying
Cutting or Self-Harming Behaviors	Over Eating
Hyperactivity	Overuse of Electronics (cellphones, tablet, etc)
Impulsivity	Obsessions/Intrusive Thoughts
Isolation	Panic Attacks
Low Impulse Control	Peer Relationship Issues
Regular Stomachaches/Headaches/Physical Complaints	Perfectionism
Repetitive Behaviors	Performance Anxiety
Suicidal Thoughts or Actions	Poor Social Skills
Sleeplessness	Poor Eye Contact
School Refusal / Avoidance	Running Away
Separation Anxiety	Regression In Toilet Training
Lack of Empathy	Sensory Sensitivities (adverse reactions to loud noises, fabrics, foods etc.)
Conduct Problems	

Other: _____

Describe your goals for your child's therapy:

_____

_____

_____

Please list any information you deem to be important for the therapist to know:

_____

_____

_____

Individual Completing The Form (printed name)

_____ Date _____

Parent / Legal Guardian Signature

_____ Date _____

Counselor

GroundWork
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Adolescent Informed Consent Form

Privacy of Information Shared in Counseling/Therapy: Your Rights and My Policies

What to expect:
The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.
- You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm.
- You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- You tell me you are being abused-physically, sexually, or emotionally- or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Florida Department of Social Services.
- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

Communicating with your parent(s) or guardian(s):
Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential.

Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing _____, would you tell their parents?"

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.
[You should also know that, by law, your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records.]

Communicating with other adults:
School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you (with release of information document signed by your parent) Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission, and your parents written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

* * * * *

Adolescent Consent Form & Parent Agreement to Respect Privacy

Adolescent Client:
Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality.
If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature _____ Date_____

* * *

Parent/Guardian:
Initial boxes and sign below indicating your agreement to respect your adolescent's privacy:

_____ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

_____ Although I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

_____ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with his/her consultant/supervisor.

Parent Signature _____ Date_____

Parent Signature _____ Date_____

Counselor Signature _____ Date_____