CHAPTER 1

Administrative and Intake Forms

THE MENTAL HEALTH CLINIC'S INTAKE INFORMATION forms elicit demographic and payment information about the client. They also communicate business, legal, and ethical issues and responsibilities. Although initial intake forms do not provide specific clinical information, they do provide an understanding of the responsibilities of both the client and the clinic. In each case, these forms are taken care of prior to the first counseling session. All insurance and financial agreements are contracted with the client before services begin. The clinic's financial policies must be clearly spelled out. In addition, the client should be made aware of, and agree to, the limits of confidentiality in a counseling session.

Common client questions are: "What if my insurance company does not pay?" "How confidential is the session?" "Do parents have the right to their children's records?" "What happens if payment is not received?" "What happens if suicide is mentioned?" and "What is the price of therapy?" These and other questions are not only answered but also documented and signed. Any of these issues, if not covered, could lead to misunderstanding, subsequent premature termination of treatment, ethics changes, or a lawsuit. Intake forms provide clear communication between the client and clinic, with the aim of eliminating misunderstandings detrimental to the therapeutic process and clinic survival.

FORM 1 Screening Information

The screening information form contains demographic information that is generally held by office personnel for administrative reasons. It is filled out prior to meeting the teenager and is kept separately from the client's confidential medical records. The information contained is used for ongoing office and billing procedures in which a quick reference is needed without having to access the client's medical records.

It excludes private clinical information and is typically readily accessible to administrative/office/billing personnel. The form also provides emergency contact information as required by accrediting agencies. For example, if a client has a medical problem or becomes suicidal, information such as emergency contacts, the primary physician, and other background information must be readily available. Referral source information may be used for tracking purposes.

FORM 2 Notice of Appointment

This form serves to remind the client of an upcoming initial appointment and instructs the client on what information to bring to the session.

FORM 3 Consent to Treatment and Recipient's Rights

A statement of consent for treatment and the client's rights are common requirements of accreditation agencies. The client further acknowledges reading and understanding their rights as a patient. The form further explains various situations in which the client could be discharged from treatment nonvoluntarily and the limits of confidentiality.

FORM 4 Recipient's Rights Notification

The information contained in this client handout includes disclosures often required by accreditation agencies that inform clients of their rights as consumers of mental health services.

FORM 5 Financial Policy

Clinical skills are necessary but are not the sole component in the overall scope of mental health services. A concise, written financial policy is crucial to the successful operation of any practice. Clear financial policies and procedures eliminate much potential discord (and premature termination of services) between the client and the therapist and clinic. Clinics that thrive financially and are self-sufficient have few accounts receivable at any time. An adequate financial policy statement addresses the following:

- The client is ultimately responsible for payment to the clinic. The clinic cannot guarantee insurance benefits. (*Note:* Some managed care contracts forbid client payment to the clinic for noncovered services without permission.)
- Clinics that bill insurance companies should convey to clients the fact that billing third-party payers is simply a service—not a responsibility—of the clinic.

- ➢ There are time limits in waiting for insurance payments, after which the client must pay the clinic. Some clinics collect the entire amount initially from the client and reimburse the client when insurance money is received.
- ➢ The clinic's policy regarding payment for treatment of minors should be noted.
- ➢ The policy regarding payment for charges not covered by third-party payers should be addressed.
- ➢ The financial policy form should be signed by the person(s) responsible for payment.
- ➢ Assignment of benefit policies should be addressed.
- ➢ The financial policy statement should specify when payments are due and policies for nonpayment.
- ➢ Methods of payment should be listed.

Request clients to read and sign the financial policy statement (Form 5) prior to the first session. Some mental health providers ask clients to come to the first session 15 to 20 minutes early to review the initial policies and procedures. Take care of all financial understandings with the client before the first session begins; otherwise, valuable session time might be taken up reviewing financial issues.

When this information is unclear or unknown, there is room for misunderstanding between the mental health care provider and the client. Clients usually believe that all services performed in therapy are covered by their insurance. But mental health benefits from several sources are decreasing, and only specific, limited services are now covered. For example, just a few years ago several third-party payers paid for testing; today testing is seldom considered a standard procedure and often needs prior approval. Another trend is that most managed care companies approve only a set number of sessions at a time, while in the past few restrictions were made.

Initial insurance information provided by third-party payers is not a guarantee of benefits. Each mental health care provider should have a clear financial policy and payment contract (possibly on the same form) to explain conditions of payment in the event that the third-party payer denies payment.

FORM 6 Payment Contract for Services

Along with the financial policy statement, the payment contract is vital for the clinic's financial survival. Without a payment contract, clients are not clearly obligated to pay for mental health services. The payment contract (Form 6) meets federal criteria for a truth in lending disclosure statement for professional services and provides a release of information to bill third parties.

The contract lists professional fees that will be charged. (A clinical hour should be defined by the number of minutes it covers rather than stating "per hour.") Interest

rates on late payments must be disclosed. Other services provided by the mental health care provider must also be listed, and costs should be disclosed. Fees for services such as testing should be listed, either by the test or at an hourly rate for testing and interpretation time. The contract should cover specific clinic policies regarding missed appointments, outside consultations, and other potential fees related to the mental health care provider.

The mental health care provider may choose to include or omit estimated insurance benefits in the payment contract. Since the mental health clinic is not directly affiliated with the third-party payer and its changing policies, it is important to clearly state that payment is due regardless of decisions made by the third-party payer and that the client is financially responsible to the clinic for any amounts not paid by the third-party payer within a certain time frame.

FORM 7 Code of Ethics and Mission Statement

Accreditation agencies require that clinics post a mission statement. This form contains a sample mission statement and the ethical stance of a clinic. Typically this is posted in a conspicuous place in the waiting room.

FORM 8 Therapist's Ethics Statement

This form is signed by each therapist in the clinic as a means to document their compliance with the ethical stances of the clinic and their professional association.

FORM 9 Agreement Regarding Minors

This form provides an agreement that parents will respect certain rules of privacy regarding what their children disclose in therapy.

FORM 10 Preauthorization for Health Care

Charge cards are an effective means of collecting fees for professional services. The following form provides several benefits. It allows the clinic to automatically bill the charge-card company for third-party payments not received after a set number of (often 60) days. It eliminates expensive—and often ineffective—billing to the client and successive billing to the insurance company. It further allows the clinic to bill the charge-card company for recurring amounts, such as co-payments. This policy is often welcomed by clients because it eliminates the need to write a check each time services are received.

Most banks offer both VISA and MasterCard dealer status, but established credit is needed. Some therapists have become vendors for credit-card companies by offering

to back the funds with a secured interest-bearing account (e.g., $500) for a set period while their credit becomes established with the bank.

Fees for being a charge-card dealer vary and may be negotiated, so competitive shopping for a bank is suggested. Some banks charge a set percentage of each transaction, while others include several hidden fees. The process is simpler when the same bank is used in which the mental health professional has a checking account, because charge account receipts are generally deposited into a checking account.

FORM 11 Confidentiality Agreement

Form 1 Screening Information

Please Print Clearly THIS SHEET MUST BE FILLED IN COMPLETELY Readmit: ____ Yes ____ No
Date _____ Client's Social Security # _____ Case # _____
Client's First Name _____ Last Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Telephone (Home) _____ (Work) _____
Birthdate _____/_____/_____ Age _____ Gender _____F _____M Race _____
Name of Spouse/Guardian _____ Phone _____
Address _____ City _____ State _____ Zip _____
Person Responsible for Payment _____ Soc. Sec. # _____
Signature of Person Responsible for Payment X _____ (Must be signed for services to begin)

Emergency Information
In case of emergency, contact:
Name (1) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____

Name (2) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____

Physician _____ Phone _____
Address _____ City _____ State _____ Zip _____

Psychiatrist _____ Phone _____
Address _____ City _____ State _____ Zip _____

Other Physicians _____ Phone _____

Current Medications _____
Allergies _____

Employment Information (If client is a child, use parent's employment)
Client/Guardian: Place _____ Phone _____ Hrs _____
Spouse: Place _____ Phone _____ Hrs _____

Insurance Information

Primary Insurance _____	Secondary Insurance _____
Phone _____	Phone _____
Contract/ID# _____	Contract/ID# _____
Group/Acct# _____	Group/Acct# _____
Subscriber _____	Subscriber _____
Subscriber Date of Birth _____	Subscriber Date of Birth _____
Client's relationship to Subscriber	Client's relationship to Subscriber
___Self ___Spouse ___Child ___Other_____	___Self ___Spouse ___Child ___Other_____

PROVISIONS: Client pays $_____ Deductible amount Amount satisfied: $_____
Insurance pays_____ % for visits_____ – _____ and_____ % for visits_____ – _____
Type(s) of providers covered: _____ Supervision: _____
Prior authorization needed: _____
Effective date: _____ Policy anniversary: _____
Coverage for testing: _____ Annual limit: _____

Referral Source
How did you hear of our clinic (or from whom)?_____
Address _____ City _____ State _____ Zip _____
Phone _____ Relationship to referral source _____

Form 2 Notice of Appointment

Date: _____

Dear: _____

This is to confirm your appointment with _____(therapist's name)_____ at our clinic on _____(date)_____.

Your appointment time is at _____; however, please arrive _____ minutes early to fill out insurance and clinical forms. The appointment will last approximately _____ minutes.

Address of clinic _____

_____

_____

Please bring the following information to the clinic:

_____ _____

_____ _____

_____ _____

If you have any questions or must cancel your appointment, please phone the clinic at _____(phone number)_____ at least _____ hours in advance.

Sincerely,

_____

Form 3 Consent to Treatment and Recipient's Rights

Client_____ Chart #_____

I, _____ the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at _____(name of clinic)_____, hereby referred to as the Center. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Recipient's Rights Advisor.

Nonvoluntarily Discharge from Treatment: A client may be terminated from the Center nonvoluntarily. if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the nonvoluntary discharge by letter. The client may appeal this decision with the Clinic Director or request to reapply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the Center is protected by federal and/or state law and regulations. Generally, the Center may not say to a person outside the Center that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: (1) the patient consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a patient either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Center's duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of nonemancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above-stated policies and agreements with _____(name of clinic)_____.

_____ _____
Signature of Client/Legal Guardian Date
(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____
Witness Date

Form 4 Recipient's Rights Notification

As a recipient of services at our facility, we would like to inform you of your rights as a patient. The information contained in this brochure explains your rights and the process of complaining if you believe your rights have been violated.

Your rights as a patient

1. Complaints. We will investigate your complaints.
2. Suggestions. You are invited to suggest changes in any aspect of the services we provide.
3. Civil rights. Your civil rights are protected by federal and state laws.
4. Cultural/spiritual/gender issues. You may request services from someone with training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, we will help you in the referral process.
5. Treatment. You have the right to take part in formulating your treatment plan.
6. Denial of services. You may refuse services offered to you and be informed of any potential consequences.
7. Record restrictions. You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.
8. Availability of records. You have the right to obtain a copy and/or inspect your protected health information; however, we may deny access to certain records. If so, we will discuss this decision with you.
9. Amendment of records. You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.
10. Medical/legal advice. You may discuss your treatment with your doctor or attorney.
11. Disclosures. You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

Your rights to receive information

1. Medications used in your treatment. We will provide you with information describing any potential risks of medications prescribed at our facility.
2. Costs of services. We will inform you of how much you will pay.
3. Termination of services. You will be informed as to what behaviors or violations could lead to termination of services at our clinic.
4. Confidentiality. You will be informed of the limits of confidentiality and how your protected health information will be used,
5. Policy changes.

Our ethical obligations

1. We dedicate ourselves to serving the best interest of each client.
2. We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
3. We maintain an objective and professional relationship with each client.
4. We respect the rights and views of other mental health professionals.
5. We will appropriately end services or refer clients to other programs when appropriate.
6. We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.
7. We respect various institutional and managerial policies but will help to improve such policies if the best interest of the client is served.

Patient's responsibilities

1. You are responsible for your financial obligations to the clinic as outlined in the Payment Contract for Services.
2. You are responsible for following the policies of the clinic.
3. You are responsible to treat staff and fellow patients in a respectful, cordial manner in which their rights are not violated.
4. You are responsible to provide accurate information about yourself.

What to do if you believe your rights have been violated

If you believe that your patient rights have been violated, contact our Recipient's Rights Advisor or Clinic Director.

Form 5 Financial Policy

The staff at (_____) (hereafter referred to as the clinic) are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services, we have established a financial policy that provides payment policies and options to all consumers. The financial policy of the clinic is designed to clarify the payment policies as determined by the management of the clinic.

The Person Responsible for Payment of Account is required to sign the form Payment Contract for Services, which explains the fees and collection policies of the clinic. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, the clinic will bill insurance companies and other third-party payers but cannot guarantee such benefits or the amounts covered and is not responsible for the collection of such payments. In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections. A 1% per month interest rate is charged for accounts over 60 days.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the clinic), this amount will be collected by the clinic until the deductible payment is verified to the clinic by the insurance company or third-party provider.

All insurance benefits will be assigned to this clinic (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the Payment Contract for Services.

Payment methods include check, cash, or the following charge cards: _____
Clients using charge cards may either use their card at each session or sign a document allowing the clinic to automatically submit charges to the charge card after each session.

Questions regarding the financial policies can be answered by the Office Manager.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account: _____ Date:_____/_____/_____

Co-responsible party: _____ Date:_____/_____/_____

Form 6 Payment Contract for Services

Name(s):_____
Address: _____ City: _____ State: _____ Zip: _____
Bill to: Person responsible for payment of account: _____
Address: _____ City: _____ State: _____ Zip: _____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One Fees for Professional Services
I (we) agree to pay _____, hereafter referred to as the clinic, a rate of $ _____ per clinical unit (defined as 45–50 minutes for assessment, testing, and individual, family and relationship counseling).
A fee of $ _____ is charged for group counseling. The fee for testing includes scoring and report-writing time.
A fee of $ _____ is charged for missed appointments or cancellations with less that 24 hours' notice.
A fee of $ _____ per hour is charged for services not covered by insurance, such as court appearances, extra report writing time, and any other services not covered by insurance.

Part Two Clients with Insurance (Deductible and Co-payment Agreement)
This clinic has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated Insurance Benefits

1) $ _____ Deductible amount (paid by insured party)
2) Co-payment _____ % ($ _____/clinical unit) for first _____ visits.
3) Co-payment _____ % ($ _____ /clinical unit) up to _____ visits.
4) The policy limit is _____ per year: _____ annual _____ calendar

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services that are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be nonefficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

Part Three All Clients
Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: _____

Date: _____/_____/_____

Release of Information Authorization to Third Party

I (we) authorize _____ to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above-listed third-party payer or insurance company for the purpose of receiving payment directly to _____.

I (we) understand that access to this information will be limited to determining insurance benefits and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____ Date: _____/_____/_____

Person(s) receiving services: _____ Date: _____/_____/_____

Person(s) or guardian(s): _____ Date: _____/_____/_____

Form 7 Code of Ethics and Mission Statement

Mission Statement

We, at _____(name of clinic)_____, are dedicated professionals committed to providing quality mental health and substance abuse services. It is our overall goal to enhance the quality of life for individuals and families. Our belief is that all people are valuable and unique and should be treated with dignity and respect. While recognizing the potential for change, an assessment of the client's emotional, physical, spiritual, and life experience is provided in a caring environment. The growth of the individual is promoted through a course of treatment developed and executed in a timely and cost effective manner.

Ethical Stance

We, at _____(name of clinic)_____, dedicate ourselves to serving the best interest of each client.

We, at _____(name of clinic)_____, will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.

We, at _____(name of clinic)_____, maintain an objective and professional relationship with each client.

We, at _____(name of clinic)_____, respect the rights and views of other mental health professionals.

We, at _____(name of clinic)_____, will appropriately end services or refer clients to other programs when appropriate.

We, at _____(name of clinic)_____, will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.

We, at _____(name of clinic)_____, respect various institutional and managerial policies but will help improve such policies if the best interest of the client is served.

If you believe any of your rights have been violated, please ask to speak to our Recipient Rights Advisor or Clinic Director.

Form 8 Therapist's Ethics Statement

I fully understand and agree that any information I provide to _____(name of clinic)_____ concerning my background and work history shall be accurate. Client information shall not be discussed with or revealed to any non-clinic individuals. I will only discuss client information with the clinic staff, on a need-to-know basis. When I am responsible for professional service provision, I shall provide these services with dignity and respect. I understand and agree to be bound by applicable state laws and relevant accreditation standards, and to avoid any conflict of ethics or beliefs that conflict with those of a client to the extent that it influences my ability to provide appropriate treatment. I understand that I have the right and ethical obligation to request case transfer in such situations. Further, I agree to familiarize myself with the Recipient Rights law and policies, to be accountable for conducting myself in accordance with said laws and polices, and to report any client care concerns to my supervisor or the Recipient Rights Officer.

I agree with and support the following statements from the Mission Statement and Ethical Stance.

We, at _____(name of clinic)_____, dedicate ourselves to serving the best interest of each client.

We, at _____(name of clinic)_____, will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.

We, at _____(name of clinic)_____, maintain an objective and professional relationship with each client.

We, at _____(name of clinic)_____, respect the rights and views of other mental health professionals.

We, at _____(name of clinic)_____, will appropriately end services or refer clients to other programs when appropriate,

We, at _____(name of clinic)_____, will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.

We, at _____(name of clinic)_____, respect various institutional and managerial policies but will help improve such policies if the best interest of the client is served.

I pledge to uphold the ethical standards of the following:

_____ American Psychiatric Association
_____ American Psychological Association
_____ American Counselors Association
_____ National Association of Social Workers
_____ Other(s) _____

Furthermore, all business activities conducted at _____(name of clinic)_____ will be conducted in a professional, ethical manner. Therefore, _____(name of clinic)_____ specifically prohibits the following: 1) falsification of documents (time cards, charting, reports, etc.), 2) billing for services not rendered, 3) providing or receiving bribes, and 4) soliciting.

Name of Therapist (print) _____

Signature of Therapist _____ Date _____

Name of Administrator (print) _____

Signature of Administrator_____ Date_____

Form 9 Agreement Regarding Minors

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. I 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, I will evaluate and discuss these goals with you.

Because my role is that of the child's helper, I 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, *(These circumstances may vary from state to state, and the specific laws of each state must be followed.)*
- 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 I do not have control over information once it is released to a third party.

Now that the various aspects surrounding confidentiality have been stated, the specific agreement between you and your child/children follows:

I, (name) _____ (relationship to child) _____
I, (name) _____ (relationship to child) _____
agree that my/our child/children
(name) _____
(name) _____
(name) _____
should have privacy in his/her/their therapy sessions, and I agree to allow this privacy except in extreme situations, which I will discuss with the therapist. At the same time, except under unusual circumstances,

I understand that I have a legal right to obtain this information. To increase the effectiveness of the therapy, I agree to the following:

The goals of the therapy are as follows:
(by parent) _____
_____
(by child) _____
_____
_____

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 my child is/children are generally participating or not
- whether progress is generally being made or not

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.

Parent(s): Please make any additions or modifications as desired: _____
_____
Signature: _____ Date: _____/_____/_____
Signature: _____ Date: _____/_____/_____

Minor(s): Please make any additions or modifications as desired: _____
_____
Signature: _____ Date: _____/_____/_____
Signature: _____ Date: _____/_____/_____
Signature: _____ Date: _____/_____/_____

Therapist Signature: _____ Date: _____/_____/_____

Source: T. Patterson, *The Couple and Family Clinical Documentation Sourcebook* (New York: John Wiley & Sons, 1999). This material is used by permission of John Wiley & Sons, Inc.

Form 10 Preauthorization for Health Care

I authorize (_____(name of clinic)_____) to keep my signature on file and to charge my _____(type of charge card)_____ account for:

___ All balances not paid by insurance or other third-party payers after 60 days. This total amount cannot exceed $ _____.

___ Recurring charges (ongoing treatment) as per amounts stated in the signed Payment Contract for Services with this clinic.

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to this clinic.

Client's name: _____

Cardholder's name: _____

Cardholder's billing address: _____

City: _____ State: _____ Zip: _____

Charge card number: _____ Expiration date: _____

Cardholder's signature: _____ Date: _____/_____/_____

Form 11 Confidentiality Agreement

This agreement is to protect the confidentiality of client information. Client information is defined as all types of information, including oral and written, regarding past clients, current clients, or clients who will be receiving services at _____(name of agency)_____.

The agreement further includes oral and written records of clients whose records are received by this agency but have not or do not receive(d) services. All client records, as stated in the above paragraph, are to remain confidential and not to be used for purposes other than for heath care and administration of health care.

I understand that violating confidentiality of client records may result in a civil legal action to the fullest extent of the law, termination of employment, and reporting the action to my licensure board, if applicable. I will be responsible for all legal costs if this agreement is violated.

I agree not to disclose any client information without the proper authorization set forth by HIPAA standards.

_____ _____

Name Signature

_____ _____

Address City/State/Zip

___Employee ___Contractor ___Other _____

Title _____