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**CONFIDENTIALITY AGREEMENT**  
**Signed by Both Partners**

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

Required disclosure will occur in the following circumstances:

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

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

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

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

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

- ❖ I view the family or couple as a "treatment unit."
- ❖ I will not reveal any individual's confidences to others in the treatment unit.
- ❖ It is important for you to be aware that secrets shared individually with me are generally not healthy for you or your family/couple relationships. For this reason, if an individual member or subset of the family/couple discloses a confidence that has bearing on other participating members, I will

encourage the person(s) to reveal the information to the other member(s). I will provide support for you in finding ways to disclose the information and will help you deal with the implications of a revelation should it occur. I like to say that I am willing to be a temporary secret “holder” while we work together to find ways to share openly, but I cannot and will not be a long-term secret “keeper”.

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

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**INFORMED CONSENT**  
**Signed by Both Partners**

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

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

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

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

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

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**SHARED INFORMATION: Partner A**  
**Individual Sessions in the Context of Couples Therapy**

I, \_\_\_\_\_, understand that \_\_\_\_\_ is seeing me for individual sessions in the context of Couple/Family therapy with \_\_\_\_\_. I understand, therefore, that any material we discuss in individual sessions may be brought up in couples' sessions if my therapist believes it would be helpful to the course of therapy. I understand that my therapist will give me the opportunity to share with my partner/family member the information identified as important for couple/family work prior to the therapist doing so, and that my therapist will never disclose information to my partner without my knowledge.

If there is material discussed in individual sessions that I do not want shared with \_\_\_\_\_, I must specifically request that my therapist keep that issue confidential. I understand that if my therapist believes that the material in question is important for the couple/family work but I do not want it shared, the therapist has the right to terminate therapy.

I have read and understand these guidelines for individual sessions within couple/family therapy. I have had ample opportunity to ask questions about these guidelines. I understand that my permission to share information from these sessions terminates immediately upon the discontinuation of couple/family therapy.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**SHARED INFORMATION: Partner B**  
**Individual Sessions in the Context of Couples Therapy**

I, \_\_\_\_\_, understand that \_\_\_\_\_ is seeing me for individual sessions in the context of Couple/Family therapy with \_\_\_\_\_. I understand, therefore, that any material we discuss in individual sessions may be brought up in couples' sessions if my therapist believes it would be helpful to the course of therapy. I understand that my therapist will give me the opportunity to share with my partner/family member the information identified as important for couple/family work prior to the therapist doing so, and that my therapist will never disclose information to my partner without my knowledge.

If there is material discussed in individual sessions that I do not want shared with \_\_\_\_\_, I must specifically request that my therapist keep that issue confidential. I understand that if my therapist believes that the material in question is important for the couple/family work but I do not want it shared, the therapist has the right to terminate therapy.

I have read and understand these guidelines for individual sessions within couple/family therapy. I have had ample opportunity to ask questions about these guidelines. I understand that my permission to share information from these sessions terminates immediately upon the discontinuation of couple/family therapy.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**FEE SCHEDULE AND PAYMENT AGREEMENT**

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

	<u>Lindsey</u>	<u>Kara or Cara</u>	<u>Laura or Shy</u>
50-minute session	\$180.00	\$160.00	\$140.00
90-minute session	\$270.00	\$240.00	\$210.00
Prepare/Enrich 5-session package	\$1150.00	\$1050.00	\$950.00

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

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

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

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

Name of Client(s) \_\_\_\_\_

Cardholder’s Name (exactly as it appears) \_\_\_\_\_

Type of card:       Visa               MasterCard               Discover               American Express

Credit card number: \_\_\_\_\_

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

Cardholder’s Billing Address \_\_\_\_\_

Email where receipt should be sent \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Cardholder

\_\_\_\_\_  
Date

CLIENT DATA FORM – Partner A

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

Personal Information:

Today’s Date: \_\_\_\_\_

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_

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

Cell phone: \_\_\_\_\_  Yes  No  Preferred

Home phone: \_\_\_\_\_  Yes  No  Preferred

Work phone: \_\_\_\_\_  Yes  No  Preferred

E-mail: \_\_\_\_\_  Yes  No  Preferred

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

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

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

I was referred by another client. Her/his name is: \_\_\_\_\_

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

I was referred by another mental health provider. Her his name is: \_\_\_\_\_

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

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

Psychology Today  GoodTherapy.org  WeddingWire.com  AAMFT Therapist Locator

Other (please specify): \_\_\_\_\_

**Demographic Information:**

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Average # hours worked/week: \_\_\_\_\_ I work on  Weekdays  Evenings  Weekends

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

**Family Information:**

Relationship Status:  Single  Married  Dating  Separated  Cohabiting  Divorced  Engaged  Other \_\_\_\_\_

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

Full Name	Gender	Age	Relationship to You

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

Full Name	Gender	Age	Relationship to You



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

Are you currently taking any prescription medications?     Yes     No

If yes, which medications and why? \_\_\_\_\_  
\_\_\_\_\_

Are you currently using illegal drugs?     Yes     No

If yes, which drugs and how often? \_\_\_\_\_  
\_\_\_\_\_

Are you currently drinking excessive amounts of alcohol?     Yes     No

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

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

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

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

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Have you received therapy in the past?     Yes     No

If yes, please describe type, duration, and reason? \_\_\_\_\_  
\_\_\_\_\_

Have you ever received any psychiatric diagnoses?     Yes     No

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

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

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Therapy Information:**

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

- Individual
- Couple
- Family
- Group

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

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Please list your initial goal(s) for therapy:

1. 

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2. 

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3. 

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

Name: _____	Name: _____
Relationship to you: _____	Relationship to you: _____
Daytime phone: _____	Daytime phone: _____
Evening phone: _____	Evening phone: _____

CLIENT DATA FORM – Partner B

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

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Today’s Date: \_\_\_\_\_

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_

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

Cell phone: \_\_\_\_\_  Yes  No  Preferred

Home phone: \_\_\_\_\_  Yes  No  Preferred

Work phone: \_\_\_\_\_  Yes  No  Preferred

E-mail: \_\_\_\_\_  Yes  No  Preferred

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

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3. 

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