**Client Registration Form (Please Print)**

Name:(Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(First)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Middle)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Minor Married Single Divorced Widowed Legally Separated Other

Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male \_\_\_\_ Female \_\_\_\_\_\_\_

Race\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: Employed (FT/PT)Student Retired Self-Employed Unemployed

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party Information (If other than self):**

Responsible Party’s Name (Last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Middle) \_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex Male Female

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Relationship to Responsible or Insured Party\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Information**

Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID / Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Information (Medicaid is secondary if you also have private insurance)**

Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to

Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ins.Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID / Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Date of Birth\_\_\_\_\_\_\_\_\_\_

\*\* My role in the therapeutic process is: Client Participant

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

I have also received a copy of the office practices and protected health information disclosures.

Client (or Responsible Party) Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Please note that in family therapy sessions, the client is the child, unless otherwise stated in writing above. Family members or other participants will be asked to complete registration and to sign release of information, as appropriate. Family therapy may occur with or without the child in attendance after the initial session, depending on the needs of therapy and to allow the therapist to assess and discuss participants in varying units. Individual therapy may also require the parent, caregiver or historian to attend therapy, but this would not be considered family therapy, unless otherwise stated.

**Appointment and Office Policies for New Clients**

Please arrive at least 15 minutes before your appointment, allowing ample time for traffic and parking. You will need this time to complete and sign any forms, and time for my staff to make the necessary copies of your insurance information. For home visits, please have forms completed prior to therapist’s arrival.

**Please make sure you have your current insurance card and photo ID when you arrive for your appointment.** I provide equal access to all Clients regardless of their source of payment. Payment is expected at the time of service.

**For Established Clients**

Each time you visit the therapist, please make sure that you provide the most current insurance information and demographic information (address, phone numbers, etc.)

**In-Office Visits:** Please arrive 10 minutes before your appointment allowing ample time for traffic and parking. If you are more than 10 minutes late for your appointment, you may have to be rescheduled.

**Client Office Orientation**

Office Hours: Tuesday, Thursday - Friday (Phone messages will be returned in the afternoons during scheduled telephone hours). Saturday appointments are scheduled 2-3 times per month: 9:00 am-4:00 pm, but only occur in the office (Phones are answered after 8:30am) (The phones will be turned over to voicemail during session times; please leave a voicemail). Individuals cannot be seen at the office without a scheduled appointment.

Contact Information: Main Phone Number: (843) 409-3234 Email: hwilliamson2016@outlook.com

**What Is Asked of You**:

* Ask questions and actively participate in your care.
* Provide history and other important information including any changes in your health and information about care outside the practice.
* Sign a Transfer of Medical Records form to have your records released and return it to the front office staff.

**I Accept the following Insurances:**

* South Carolina Fee for Service Medicaid
* Select Health (Medicaid MCO)
* Molina
* WellCare
* Absolute Total Care will be accepted in September 2018
* Please call the office to check if I am a participating partner with your insurance company. I may be able to set up an agreement with the agency if I am not. Additional insurances are being added as I join their provider panels.
* I am not a provider for BlueChoice Medicaid

**TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION \*\*\*Initial:**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about my privacy practices by providing you with this Notice. I must follow the privacy practices as described below. This Notice will take effect on 03/01/2017 and will remain in effect until it is amended or replaced by me.

It is my right to change my privacy practices provided law permits the changes. Before I make a significant change, this Notice will be amended to reflect the changes and I will make the new Notice available upon request. I reserve the right to make any changes in my privacy practices and the new terms of my Notice effective for all health information maintained, created and/or received by us before the date changes are made.

I will keep your health information confidential, using it only for the following purposes:

**Treatment:** I may use your health information to provide you with my professional services. I have established “minimum necessary or need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on my staff is required to sign a confidentiality statement.

**Disclosure:** I may disclose and/or share your healthcare information with other health care professionals or agencies who provide treatment and/or service to you either by fax or electronically through electronic medical records. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that I may do so. The uses and disclosures not described in the notice will be made only with authorization from the individual.

**Paymen**t: I may use and disclose your health information to seek payment for services I provide to you. This disclosure involves business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies**: I may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, I will provide you with an opportunity to object to use or disclosure. Under emergency conditions or if you are incapacitated I will use professional judgment to disclose only that information directly relevant to your care.

**Operations:** I will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to: medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** I may use or disclose your health information when I am required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) I will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement or other state agency.

**Abuse or Neglect:** As a mandated reporter, I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** I will disclose your health care information to report potential threats to yourself or others, disease / infection exposure and to prevent injury and/or disability.

**Marketing Health-Related Services:** I will not use your health information for marketing purposes.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, I may disclose it to authorized federal officials.

**Appointment Reminders:** I may use or disclosure your health information to provide you with appointment reminders, including, but not limited to, voicemail/email messages, postcards or letters.

**YOUR PRIVACY RIGHTS AS A CLIENT: \*\*\*Initial:**

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your information, you will need to complete and submit an appropriate request form. You may also request access by sending a letter to 1505 West Palmetto Street, Florence, S.C. 29501. Once approved, an appointment can be made to review a summary and explanation of your information. This does not include private psychotherapy notes kept by the therapist. Copies, if requested, will be charged according to the South Carolina State Copy Law. If you want the copies mailed to you, postage will also be charged. There are some documents which cannot be copied and mailed, such as protected testing or assessment tools, but a summary can be provided.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosure:** You have the right to receive a list of non-routine disclosures I have made of your health care information. You have the right to a list of instances in which I, or other business associates, disclosed information for reasons other than treatment, payment or healthcare operations.

**Restrictions:** You have the right to request that I place additional restrictions on use or disclosure of your health information. I do not have to agree to these additional restrictions, but if I do, I will abide by our agreement. (Except in emergencies.) This request must be submitted in writing.

**Breach:** An individual has the right to notice in the event of a breach. If a breach does occur, this practice will contact you directly to inform you.

**QUESTIONS AND COMPLAINTS**

You have the right to file a complaint if you feel I have not compiled with my Privacy Policies. If you feel I may have violated your privacy rights, or if you disagree with a decision I made regarding your access to your health information, you can complain in writing. Request a Complaint Form from my practice. I support your right to the privacy of your information and will not retaliate in any way if you choose to a file a complaint with my office or with the U.S. Department of Health and Human Services. The toll-free number for the U.S. Department of Health and Human Services is 1-888-696-6775.

HOW TO CONTACT ME

Heather Williamson, LISW-CP Telephone: (843) 409-3234 Email: [hwilliamson2016@outlook.com](mailto:hwilliamson2016@outlook.com) Address: 1505 West Palmetto Street, Florence, S.C. 20501 (Address by appointment only).

Consent for Release of Confidential Information

**If multiple parties and/or agencies will be receiving this information, specify each party/agency below that will be receiving this information. Guardian and Client’s name should be given here if appropriate.**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Heather Williamson, LISW-CP to disclose to or to receive from (Provider/Recipient of Confidential Information) for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_as indicated below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department of Social Services

(County name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department of Mental Health

(County name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Other: List specific agency, court or person(s) or relationship)

the following information: (Client needs to initial each applicable category that or choose “All”.

\_\_\_\_\_\_ ALL

\_\_\_\_\_\_ My name and other personal identifying information;

\_\_\_\_\_\_ Substance abuse records, including treatment and diagnoses;

\_\_\_\_\_\_ Mental health records, including treatment plans and diagnoses;

\_\_\_\_\_\_ Assessments;

\_\_\_\_\_\_ Dates that services were provided;

\_\_\_\_\_\_ Recommendations for treatment;

\_\_\_\_\_\_ Progress notes;

\_\_\_\_\_\_ Progress and compliance with treatment;

\_\_\_\_\_\_ Attendance;

\_\_\_\_\_\_ Date of discharge and discharge status;

\_\_\_\_\_\_ Discharge plan;

\_\_\_\_\_\_ All educational records, including those otherwise covered by FERPA (Family

Educational Rights & Privacy Act);

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This otherwise confidential information will be used for the following purpose(s): (**Client needs to initial each applicable category that applies)**

\_\_\_\_\_\_ Monitor progress or lack of progress in treatment;

\_\_\_\_\_\_ Provide appropriate services and referrals for me;

\_\_\_\_\_\_ Provide appropriate services and referrals for my family;

\_\_\_\_\_\_ Update my Child and Family Team of my progress or lack of progress in treatment;

\_\_\_\_\_\_ Update the Courts or parties to my case about my progress or lack of progress in treatment;

\_\_\_\_\_\_ Obtain records and history to inform treatment and treatment planning;

\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***For Substance Abuse Clients:*** I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that, except for action already taken, I may revoke this consent at any time.

***For Mental Health Clients*:** I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I also understand that, except for action already taken, I may revoke this consent at any time.

***Protected Health Information:***

I understand that my health information is protected under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. pts 160& 164, but once this information is disclosed pursuant to this form, it may no longer be protected by HIPAA and further redisclosure may occur. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on the consent.

I understand that generally Heather Williamson, LISW-CP

(Provider)

may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

If I do not revoke this consent, it expires automatically as follows:

1. Upon closure of my Child Protective Services/In-Home Services/Out of Home Services case, if applicable; or
2. One year from the date this consent is signed; whichever occurs first.

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date signed Client’s name and Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date signed Client’s signature or Guardian if Client is a Minor

**PAYMENT POLICY**

**Please read it, ask any questions you may have, and sign it in the space provided. A copy will be provided to you upon request.**

**Insurance:** I participate in some insurance plans and am seeking to become a provider for new ones frequently. If you are not insured by a plan I do business with, payment in full will be expected at each visit. If you are insured by a plan I do business with but do not provide my office with an updated card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions about your coverage.

**Co-payments and deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on my part to collect copayments and deductibles from Clients can be considered fraud. **Non-covered services:** Any non-covered service, should one arise, would be discussed with you in advance and a form acknowledging this would be signed.

**Proof of insurance:** All Clients must complete my Client information form before seeing the provider. We will need a copy of your driver’s license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

**Claims submission:** I will submit your claims and assist you as reasonably possible to help get your claims paid. However, your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you, unless you are a Medicaid recipient.

**Non-payment:** If your account is over 90 days past due, it will be placed with a collection agency. Once placed in collections, all fees incurred in collecting the debt, including any legal fees, will be added to the Clients balance, and become the responsibility of the Client or Guarantor. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, you and your immediate family members may be discharged from this practice. If this were to occur, you will be notified by regular and certified mail that you have 30 days to find alternative mental health care. During that 30-day period, I will only be able to meet with you on an emergency basis. **Please initial here\_\_\_\_\_\_\_\_\_\_\_.**

**Missed appointments:** My policy is to charge $25.00 for each missed appointment not cancelled within 24 hours, unless otherwise prohibited under a Medicaid contract. After three (3) no-show appointments, you will be dismissed from the practice. Please help us to serve you better by keeping your scheduled appointments. **Please initial here\_\_\_\_\_\_\_\_.**

My practice is committed to providing the best treatment to my Clients. My fees my usual and customary charges. Thank you for understanding my payment policy. Please let me know if you have any questions or concerns.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_

Client or Guardian, if a Minor

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_

**Limitation on Confidentiality when providing family therapy:**

This written policy is intended to inform you, the participants in therapy, that when I agree to family therapy, I consider the child to be the patient, unless specified in writing. However, if there is a request for the treatment records of the family therapy beyond those authorized, I will seek the authorization of participants before I release confidential information to third parties, where possible. This may not be possible if ordered by the courts or when part of a legal/DSS case or other investigation. If my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (as it is possible to do so within the boundaries of the law). However, I may need to share information learned in an individual session (or a session with only a portion of the family unit being present) with the entire treatment unit if I am to effectively offer therapy. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the family unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to provide care by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment and disclosure may be required or compelled by a court or State Agency as a part of a treatment plan. If I am not free to exercise my clinical judgment regarding the need to bring this information up, I might be placed in a situation where I will have to terminate treatment of the family. This policy is intended to prevent the need for such a termination.

We, the members of the (family or other unit) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Heather Williamson, LISW-CP and that we enter family therapy in agreement with this policy.

Dated: \_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated: \_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated: \_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated: \_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_