WELCOME to the Electronic Portion of my Continuing Education Course for Mental Health Professionals

FACING THE CHALLENGE OF LIABILITY IN PSYCHOTHERAPY: PRACTICING DEFENSIVELY

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Download these office forms into your computer and modify them to suit your taste and your needs. This disc contains model forms for psychotherapy practice including Informed Consents, Guides for Record Keeping, Contracts for Supervision and Training, HIPAA Compliance Forms, and Documents for Working with Minors and Custody Evaluations.

The original continuing education course for credits upon which this book is based can be found at www.sfrankelgroup.com. Other continuing education courses taught by the authors can be found at www.ListeningPerspectives.com, www.ContinuingEducationCentral.com, and www.Camft.org.

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SECTION ONE

INFORMED CONSENTS AND

CLIENT INFORMATION FORMS

Informed Consent for Psychotherapy Assessment Consultation

Name of the Therapist: _____

Your Name: _____

Address: _____

Day Phone: _____ Night Phone: _____

Referred by: _____Driver's License Number _____

Note: The hourly fee for Initial Assessment Consultation sessions is $_____to be rendered at the time of service. Twenty-four hour cancellation is required to avoid being charged for scheduled appointments. The purpose of these sessions is to determine your needs and to help you decide what form(s) of psychotherapy consultation may be desirable. These sessions are for assessment only. Any other psychological or counseling services are offered under a separate fee schedule and service agreement. Note: All therapists in this building maintain independent practices.

Reason for seeking Consultation: _____

_____

_____

If you have health insurance:

Name of company: _____

Policy Number: _____Group Number: _____

Telephone Number: _____

Insurance: _____

Your therapist will provide you with a paid receipt for these initial sessions suitable to be presented to your insurance carrier or to your managed care company. Contact your insurance representative for information on whether these sessions are covered. [Note: extended treatment and couple or family counseling is usually not a managed care benefit.]

I agree to pay all legal fees that might be incurred by the therapist as a result of these assessment sessions.

Confidentiality

I understand that in some instances my confidentiality is limited by law and compromised by all forms of electronic communication. [For Example: All suspicions of Child, Elder, and Dependent Adult abuse and situations in which serious physical harm is threatened toward oneself or toward someone else must be reported as mandated by law.]

Consent for Release and Exchange of Confidential Information

Professional ethics require that therapists obtain pertinent records from current and previous psychotherapists and physicians in order to work effectively with you. Should you decide to continue services beyond a few assessment sessions, an Informed Consent for Psychotherapy Consultation Treatment will be provided.

Are you currently in therapy? _____ Yes ____ No

If so, who is your current therapist?

1. Name:_____ Phone: _____

Address: _____

Who are your past therapists? Who is, your current psychiatrist?

2. Name: _____ Phone: _____

Address: _____

3. Name: _____ Phone: _____

Address: _____

I hereby give permission to the above named therapists to exchange confidential information with:

Consultant's Name: _____

Phone Number _____ **Fax Number**_____

Consultant's Address: _____

_____ _____
Client Signature Date

_____ _____
Consultant's Signature Date

Informed Consent for Dynamic Psychotherapy or Psychotherapeutic Consultation (Individual, Couple, Group, and Family)

The state expects that you will be informed of all possible contingencies that might arise in the course of psychotherapy. Please check to be sure you have read, understood, and discussed all questions with your therapist. An informed consent has the force of contract, so we cannot proceed until we reach an agreement on all items.

Name _____ Fee _____

Address _____

City _____ Zip Code _____ Phone _____

Mailing Address (If different): _____

Business Address _____

Business Phone _____ Birth Date _____

Social Security # _____ Driver's License # _____

Referred by: _____

Medical Insurance _____

Insured's Name (If different) _____

Policy Number _____ Group Number _____

Note on Cancellations: Due to the long-term nature of my practice, I must hold you responsible for all regularly scheduled consultation sessions *whether or not you are able to attend*. Should it be necessary for you to cancel an appointment, I must have three full

working days' notice in order to waive the fee. I cannot bill your insurance for missed sessions.

Note on Insurance Reimbursement: Due to the complexities and time delays of insurance reimbursements, I must ask that you pay at the beginning of each session. Or if I agree to send a bill, that you *pay in full no later than the tenth of each month*. A copy of your bill is to be submitted by you with your insurance form directly to your company. Insurance payments will be sent directly to you or will be credited to your next month's billing if sent to me, however you prefer.

Confidentiality: State law and professional ethics require therapists to maintain confidentiality except for the following situations:

1. If there is suspected child abuse, elder abuse, or dependent adult abuse.

2. "Tarasoff" or “Ewing” situations in which serious threat to a reasonably well-identified victim is communicated to the therapist.

3. When threat to injure or kill oneself is communicated to the therapist.

4. If you are required to sign a release of confidential information by your medical insurance.

5. If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. Think carefully and consult with an attorney before you sign away your rights. We can discuss some foreseeable possibilities together.

6. Clients being seen in couple, family, and group work are obligated legally to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in the treatment process. Secrets cannot be kept by the therapist from others involved in your treatment process.

7. 1 may at times speak with professional colleagues about our work without asking permission, but all identities will be disguised.

8. My personal secretary and office manager have access to locked and coded records but are legally charged with confidentiality.

9. Clients under 18 do not have full confidentiality from their parents.

10. It is also important to be aware of other potential limits to confidentiality that include the following:

- All records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances. Most records are stored in locked files but some are stored in secured electronic devices.
- Cell phones, portable phones, faxes and e-mails are used on some occasions.
- All electronic communication compromises confidentiality.

About the Relationship with the Therapist

Because of the nature of psychotherapy, the therapeutic relationship has to be different from most relationships. It may differ in how long it lasts, in the topics we discuss, or in the goals of our relationship. It must also be limited to the relationship of therapist and client only. If we were to interact in any other ways, we would then have a

"dual relationship". Therapy professions have rules against such relationships to protect us both.

- I cannot be your supervisor, teacher, or evaluator.
- I cannot be a therapist to my own relatives, friends (or the relatives of friends), people I know socially, or business contacts. I cannot have any other kind of business relationship with you besides the therapy itself.
- I cannot give legal, medical, financial, or any other type of professional advice.
- I cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client.

There are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions. A therapist offers you choices and helps you consider what is best for you.

You should also know that therapists are required to keep the identity of their clients confidential. Therefore, if you have any particular preferences about public meetings, let me know, otherwise I may ignore you when we encounter each other in a public place. I must decline to attend your family's gatherings if you invite me. Lastly, when therapy is completed, I will not be able to socialize with you like your other friends. In sum, my duty as therapist is to care for you and my other clients, but only in the professional role of therapist. I am not permitted to give or to receive gifts from clients except tokens with personal meaning to the therapy process.

Fees: The fee for service generally covers a 45-minute session and will be agreed upon in the first treatment session and payable at the time service is rendered. If I agree to bill you at the end of the month full payment is required by the tenth of the next month. Cost of living increases may occur on an annual basis. Telephone calls may be charged at approximately the same rate as personal consultation plus any telephone company charges. Interest at 12% per annum will be charged on all accounts over 60 days due.

Availability: The therapist is available for regularly scheduled appointment times. Dates of vacations and other exceptions will be given out in advance if possible. Telephone appointment times can be made by calling the office during regular office hours.

Emergency numbers where the therapist can sometimes be reached: _____.

Emergency service can be obtained at _____

_____.

Termination of Treatment: The therapist may terminate treatment if payment is not timely, if prescriptions are not filled (such as seeking consultation, refraining from dangerous practices, coming to sessions sober, etc.), or if some problem emerges that is not within the scope of competence of the therapist or if the therapist experiences the interaction as abusive. Clients have the right to terminate at any time but the usual minimal termination for an ongoing treatment process is four to ten sessions and a satisfying termination to long-term work may take a number of months.

Clients are urged to consider the risks that major psychological transformation may have on current relationships and the possible need for psychiatric consultation during periods of extreme depression or agitation. Not all people experience improvement from psychotherapy and therapy may be emotionally painful at times. For information on other kinds of treatment in our community call _____.

Patients have the right to refuse or to discontinue services at any time and complaints can be addressed to _____.

A brief list of the professional credentials of your therapist is attached.

What Is Dynamic Psychotherapy?

Dynamic psychotherapy originated with the work of Dr. Sigmund Freud in Vienna in the late nineteenth century. Therapy is both a way of understanding human emotions and of helping people with their relationships and their personal problems. The mature or rational self that functions more or less successfully in the real world is only a part of the total person. The more immature, irrational, or unconscious self functions silently in the background to produce various symptoms and maladaptive behaviors that often intrude into the person's social life, personal relationships, school or work activities, and physical health. In dynamic psychotherapy specific problems are viewed in the context of the whole person. The quest for self-knowledge is seen as the most important key to changing attitudes and behavior.

Dynamic psychotherapy is based on the insight that our personalities are the result of passing through and solving relationship issues at many developmental stages. At any

stage, the way we have reacted to events in our lives may have caused us to get stuck at a certain level of insight or problem solving. While we go ahead and mature satisfactorily, in many ways we may carry within us the parts that didn't have a chance to develop. We can have a mature exterior and be functioning more or less successfully, while internally we may feel vulnerable, confused, depressed, angry, afraid, and childlike. We may not feel able to bounce back from rejection, get past blocks, allow our real feelings to surface, or stay in touch with our feelings and desires. Our physical health may be compromised in many ways by emotional and relationship issues.

Dynamic psychotherapy is designed to help the client get in touch with her or his unconscious memories, feelings, and desires that are not readily available to the conscious mind. Therapy is designed to help clients of all ages understand how their unconscious feelings and thoughts affect the ways they act, react, think, feel, and relate. Whether or not therapy works depends a great deal on the client's willingness and ability to experience all relationships deeply, especially the therapeutic relationship. Each client, by expressing her or his story in whatever ways possible to someone who knows how to listen and to give new meanings back, has the opportunity to learn about herself or himself in a new way.

Dynamic psychotherapy can provide a safe place for people of whatever age to discover for themselves their own truths. It provides a unique opportunity to re-experience personal history in a new relationship, to see it in a new way, and to make connections between past and current conflicts that illuminate the way one relates to oneself and to others.

Clients are encouraged to talk about thoughts and feelings that come up about therapy or about the therapist. These feelings are important because elements of one's earliest affections and hostilities toward parents and siblings are often shifted onto the therapist and the process of therapy. This phenomenon, known as "transference," offers a rich source of understanding, for it offers the possibility for people to re-experience and re-work important feelings arising from the past with the maturity they possess in the present.

Dynamic psychotherapy is usually not a short-term therapy as it takes time to explore the complex layers of feeling and experience that make up a person's own unique relationship history. People find that their therapy can easily extend for several years but there is no prescribed length of treatment. Only the people closely involved have a sense of when personal goals have been met. When the client feels she or he has accomplished the desired goals, then a termination date can be set and agreed upon.

Dynamic psychotherapy aims to help people experience life more deeply, enjoy more satisfying relationships, resolve painful conflicts, and better integrate all the parts of their personalities. Perhaps its greatest potential gift is the essential freedom to change and to continue to grow in relationships.

Agreement for Dynamic Psychotherapy Consultation

I have read this informed consent completely and have raised any questions I might have about it with my therapist. I have received full and satisfactory response and agree to the provisions freely and without reservations.

I understand that my therapist is responsible for maintaining all professional standards set forth in the ethical principles of his/her professional association as well as the laws of the state of _____ governing the practice of psychotherapy and that he/she is liable for infractions of those standards.

I understand that I will be fully responsible for any and all legal and/or collection costs arising as a result of my contact with my therapist, including compensation at our agreed upon rate for his or her time involved in preparing for and doing court work.

I understand that my therapist from time to time makes teaching and research contributions using disguised client material. By consenting to treatment I am giving consent to this process of professional contribution and the right to use disguised material without financial remuneration.

Arbitration Agreement

I agree to address any grievances I may have directly with my therapist immediately. If we cannot settle the matter between us, then a jointly agreed-upon outside consultation will be sought. If not, an arbitration process will be initiated under the auspices of the American Arbitration Association, which will be considered as a complete resolution and legally binding decision under state law, which [in California] states us follows:

"NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ONE OF THIS CONTRACT."

[Note: California Law requires that the above sentence be printed in .12 red ink]

Article 1: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by [state] law, and not by lawsuit or resort to court process except as [state] law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." Any arbitration process will be considered as a complete resolution and legally binding decision. The client will be responsible for the costs of this process. In agreeing to treatment, you are consenting to the above identified grievance procedures.

This agreement constitutes the entirety of our professional contract. Any changes must be signed by both parties. I have a right to keep a copy of this contract.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

_____ _____

Legal Parent or Guardian Signature Date

Statement of the Therapist

This document was discussed with the client and questions regarding fees, diagnosis, and treatment plan were discussed. I have assessed the client's mental capacity and found the client capable of giving an informed consent at this time.

Date and Initial of Therapist _____.

Informed Consent for Infant Relationship-Based Therapy

Child's Name _____

Parents' Names _____

Address _____

City _____ Zip Code _____ Phone _____

Business Phone _____ Birth Date _____

Infant Therapy addresses pre-linguistic and emerging verbal communication of infants, toddlers, and young children with their parents or caretakers. The work, based on infant developmental research, is characterized by the therapist coaching the parent, who interacts with the child. The goal is to facilitate the natural unfolding of the child's developing interpersonal communication and to eliminate the need for the child to engage in maladaptive behavior patterns. Some of the work is videotaped so interactional sequences can be reviewed by the therapist and parent in order to document behavioral change and to identify emerging abilities in the child that are ready to be addressed.

Confidentiality: Law and professional ethics require therapists to maintain confidentiality except when there is suspicion of child abuse, elder or dependent adult abuse, or serious threats of harm to oneself or another person. Communication regarding the therapy to other licensed educational and health care providers requires the parent's written permission. I am also aware that psychotherapists utilize professional consultation while maintaining the family's anonymity.

Note on Cancellations: Seventy-two hour notice is required for canceling an appointment or failing to show without canceling. If you miss a session without sufficient notification, you will be charged the full fee. I cannot bill insurance for missed appointments.

Note on Insurance Reimbursement: Due to the complexities and time delays of insurance reimbursements, I ask that you pay your bill when service is rendered. Upon request you will be given a monthly statement. Send it directly to your insurance company. Insurance payments will be sent directly to you or credited to your next month's billing, however you prefer.

Fees: All consultations are based on a forty-five minute hour. It is important to be on time as a late arrival cannot be made up by going overtime. Preparation of written reports and attendance at school conferences will be billed at the regular hourly rate for time spent. It is generally expected that fees will be paid at the time service is rendered. The original fee is subject to periodic increases.

Availability: The therapist is available for regularly scheduled appointment times. Notice on holidays, vacation, and other exceptions will be given out in advance if possible.

Termination of Treatment: The therapist may terminate treatment if payment is not timely, if prescriptions are not fulfilled (such as seeking consultation), or if some problem

emerges that is not within the therapist's scope of competence. It is important that termination be discussed in session.

Arbitration Agreement

I agree to address any grievances I may have directly with the therapist immediately. If we cannot settle the matter between us then a jointly agreed-upon outside consultation will be sought. If not, an arbitration process will be initiated under the auspices of the American Arbitration Association which will be considered as a complete resolution and legally binding decision under state law which states as follows: "NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GMNG UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ONE OF THIS CONTRACT."

[Note: California Law requires that the above sentence be printed in .12 red ink]

Article 1: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by [state] law, and not by lawsuit or resort to court process except as Estate] law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

Any arbitration process will be considered as a complete resolution and legally binding decision. The client will be responsible for the costs of this process. In agreeing

to treatment, you are consenting to the above. This agreement constitutes the entirety of our professional contract. Any changes must be signed by both parties. I have a right to keep a copy of this contract.

I have read this informed consent completely and have raised any questions I might have about it with the therapist. I understand that I have a right to a copy of this agreement and that any additional considerations will likewise be put into writing and signed by both parties.

Parent's Signature _____Date _____

Therapist's Signature _____Date _____

Legal Guardian's Signature _____Date _____

Verification Statement of the Therapist

This document was discussed with the client and questions regarding fees, diagnosis, and treatment plan were discussed. I have assessed the parent's or guardian's mental capacity and found her or him capable of giving an informed consent at this time.

_____

Therapist's Signature Date

Informed Consent for Work with Children and Adolescents
(to be completed by custodial parent or legal guardian)

Note: The state expects that you will be informed of all possible contingencies that might arise in the course of short- and long-term therapy with your child. Please check to be sure you have read, understood, and discussed all questions with the therapist. An informed consent has the force of contract so we cannot proceed until we reach an agreement on all items.

Name of Child or Adolescent _____

Age _____ Birth Date _____ Child's Phone Number _____

Fee _____ Custodial Parent or Legal Guardian's Name _____

Note on Legal Custody: If parents are separated, legally separated or divorced or the child or adolescent is otherwise under custodial care or guardianship you must submit with this informed consent the documentation giving you the legal right to pursue medical/psychological treatment for the child. I cannot work with your child without this document.

Address _____

City _____ Zip Code _____ Phone _____

Mailing Address (if different) _____

Business Address _____

Business Phone _____ Birth Date _____

Social Security # _____ Driver's License # _____

Referred by: _____

Medical Insurance _____

Insured's Name (if different) _____

Policy Number _____ Group Number _____

Note on Cancellations: Due to the long-term nature of my practice, I must hold you responsible for all regularly scheduled consultation sessions *whether or not you are able to attend*. Should it be necessary for you to cancel an appointment I must have at least three full working days notice in order to waive the fee. I cannot bill your insurance for missed sessions.

Note on Insurance Reimbursement: Due to the complexities and time delays of insurance reimbursements, I must ask that you pay at the beginning of each session or if I agree to send a bill that you *pay in full no later than the tenth of each month*. A copy of your bill is to be submitted by you with your insurance form directly to your company. Insurance payments will be sent directly to you or credited to your next month's billing if sent to me, however you prefer.

Confidentiality: State law and professional ethics require therapists to maintain confidentiality except for the following situations:

1. If there is suspected child abuse, elder abuse, or dependent adult abuse.

2. "Tarasoff" or “Ewing” situations in which serious threat to a reasonably well-identified victim is communicated to the therapist.

3. When threat to injure or kill oneself is communicated to the therapist.

4. If you are required to sign a release of confidential information by your medical insurance.

5. If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. **Think carefully and consult with an attorney before you sign away your rights.** We can discuss some foreseeable possibilities together.

6. Clients being seen in couple, family, and group work are obligated legally to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in the treatment process. Secrets cannot be kept by the therapist from others involved in your treatment process.

7. 1 may at times speak with professional colleagues about our work without asking permission, but all identities will be disguised.

8. My personal secretary and office manager have access to locked and coded records but are legally charged with confidentiality.

9. Clients under 18 do not have full confidentiality from their parents. 10. It is also important to be aware of other potential limits to confidentiality that include the following:

• All records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances. Most records are stored in locked files but some are stored in secured electronic devices.

• Cell phones, portable phones, faxes and e-mails are used on some occasions.

• All electronic communication compromises confidentiality.

Special note on confidentiality with children and adolescents: Psychotherapy with people of any age relies on the client's confidence that what is shared with the therapist is private and confidential. While parents and guardians have the right to know general information about how the therapy with their child is progressing, **in signing this form you waive the right to know the private details of the child's therapy or to have access to the confidential therapy records of the child.** A general summary can be provided at any time upon request.

About the Relationship with the Therapist

Because of the nature of psychotherapy, the therapeutic relationship has to be different from most relationships. It may differ in how long it lasts, in the topics we discuss, or in the goals of our relationship. It must also be limited to the relationship of therapist and client only. If we were to interact in any other ways, we would then have a "dual relationship". Therapy professions have rules against such relationships to protect us both.

- I cannot be your supervisor, teacher, or evaluator.

- I cannot be a therapist to my own relatives, friends (or the relatives of friends), people I know socially, or business contacts. I cannot have any other kind of business relationship with you besides the therapy itself.
- I cannot give legal, medical, financial, or any other type of professional advice.
- I cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client.

There are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions. A therapist offers you choices and helps you consider what is best for you.

You should also know that therapists are required to keep the identity of their clients confidential. Therefore, if you have any particular preferences about public meetings, let me know, otherwise I may ignore you when we encounter each other in a public place. I must decline to attend your family's gatherings if you invite me. Lastly, when therapy is completed, I will not be able to socialize with you like your other friends. In sum, my duty as therapist is to care for you and my other clients, but only in the professional role of therapist. I am not permitted to give or to receive gifts from clients except tokens with personal meaning to the therapy process.

Fees: The fee for service generally covers a 45-minute session and will be agreed upon in the first treatment session. Payment is rendered at the time of service unless an arrangement is made for end-of-the-month billing with full payment required by the tenth of the next month. Cost of living increases may occur on an annual basis. Telephone calls

may be charged at approximately the same rate as personal consultation plus any telephone company charges. Interest at 12% per annum will be charged on all accounts over 60 days due.

Availability: The therapist is available for regularly scheduled appointment times. Dates of vacations and other exceptions will be given out in advance if possible. Telephone appointment times can be made by calling the office during regular office hours.

Emergency numbers where the therapist can sometimes be reached: _____

Emergency service can be obtained at: _____

_____

Termination of treatment: The therapist may terminate treatment if payment is not timely, if prescriptions are not filled (such as not seeking required consultations, parents not doing requested parallel work, or regularly scheduled sessions not being kept), or if some problem emerges that is not within the scope of competence of the therapist or the therapist is experiencing the interaction as abusive. The usual minimal termination for an ongoing treatment process is four to ten sessions but a satisfying termination to long-term work may take several months.

Clients are urged to consider the risks that major psychological transformation may have on current relationships and the possible need for psychiatric consultation during periods of extreme depression or agitation. Not all people experience improvement from

psychotherapy and therapy may be emotionally painful at times. For information on other forms of treatment available in our community call: _____.

Clients have the right to refuse or to discontinue services at any time and complaints can be addressed to: _____.

A brief list of the professional credentials of your therapist is attached.

What Is Dynamic Psychotherapy?

Dynamic psychotherapy originated with the work of Dr. Sigmund Freud in Vienna in the late nineteenth century. Therapy is both a way of understanding human emotions and of helping people with their relationships and their personal problems. The mature or rational self that functions more or less successfully in the real world is only a part of the total person. The more immature, irrational, or unconscious self functions silently in the background to produce various symptoms and maladaptive behaviors that often intrude into the person's social life, personal relationships, school or work activities, and physical health. In dynamic psychotherapy specific problems are viewed in the context of the whole person. The quest for self-knowledge is seen as the most important key to changing attitudes and behavior.

Dynamic psychotherapy is based on the insight that our personalities are the result of passing through and solving relationship issues at many developmental stages. At any stage, the way we have reacted to events in our lives may have caused us to get stuck at a certain level of insight or problem solving. While we go ahead and mature satisfactorily,

in many ways we may carry within us the parts that didn't have a chance to develop. We can have a mature exterior and be functioning more or less successfully, while internally we may feel vulnerable, confused, depressed, angry, afraid, and childlike. We may not feel able to bounce back from rejection, get past blocks, allow our real feelings to surface, or stay in touch with our feelings and desires. Our physical health may be compromised in many ways by emotional and relationship issues.

Dynamic psychotherapy is designed to help the client get in touch with her or his unconscious memories, feelings, and desires that are not readily available to the conscious mind. Therapy is designed to help clients of all ages understand how their unconscious feelings and thoughts affect the ways they act, react, think, feel, and relate. Whether or not therapy works depends a great deal on the client's willingness and ability to experience all relationships deeply, especially the therapeutic relationship. Each client, by expressing her or his story in whatever ways possible to someone who knows how to listen and to give new meanings back, has the opportunity to learn about herself or himself in a new way.

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Clients are encouraged to talk about thoughts and feelings that come up about therapy or about the therapist. These feelings are important because elements of one's earliest affections and hostilities toward parents and siblings are often shifted onto the

therapist and the process of therapy. This phenomenon, known as "transference," offers a rich source of understanding, for it offers the possibility for people to re-experience and re-work important feelings arising from the past with the maturity they possess in the present.

Dynamic psychotherapy is usually not a short-term therapy as it takes time to explore the complex layers of feeling and experience that make up a person's own unique relationship history. People find that their therapy can easily extend for several years but there is no prescribed length of treatment. Only the people closely involved have a sense of when personal goals have been met. When the client feels she or he has accomplished the desired goals, then a termination date can be set.

Dynamic psychotherapy aims to help people experience life more deeply, enjoy more satisfying relationships, resolve painful conflicts, and better integrate all the parts of their personalities. Perhaps its greatest potential gift is the essential freedom to change and to continue to grow in relationships.

Agreement for Dynamic Psychotherapy Consultation

I have read this informed consent completely and have raised any questions I might have about it with the therapist. I have received full and satisfactory response and agree to the provisions freely and without reservations.

I understand that the therapist is responsible for maintaining all professional standards set forth in the ethical principles of his/her professional association as well as

the laws of the state governing the practice of psychotherapy and that he/she is liable for infractions of those standards.

I understand that I will be fully responsible for any and all legal and/or collection costs arising as a result of contact with the therapist, including appropriate compensation for his time involved in preparing for and doing court work.

I understand that the therapist from time to time consults with other mental health professionals and makes teaching and research contributions using disguised client material. By consenting to treatment I am giving consent to these processes of professional enrichment and contribution and the right to use disguised material without financial remuneration.

Arbitration Agreement

I agree to address any grievances I may have directly with the therapist immediately. If we cannot settle the matter between us then a jointly agreed-upon outside consultation will be sought. If not, an arbitration process will be initiated under the auspices of the American Arbitration Association which will be considered as a complete resolution and legally binding decision under state law which states as follows:
"NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GMNG UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ONE OF THIS CONTRACT."
[Note: California Law requires that the above sentence be printed in .12 red ink]

Article 1: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by [state] law, and not by lawsuit or resort to court process except as Estate] law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

Any arbitration process will be considered as a complete resolution and legally binding decision. The client will be responsible for the costs of this process. In agreeing to treatment, you are consenting to the above. This agreement constitutes the entirety of our professional contract. Any changes must be signed by both parties. I have a right to keep a copy of this contract.

I have read this informed consent completely and have raised any questions I might have about it with the therapist. I understand that I have a right to a copy of this agreement and that any additional considerations will likewise be put into writing and signed by both parties.

_____ _____

Legal Parent or Guardian Signature Date

_____ _____

Therapist's Signature Date

Verification Statement of the Therapist

This document was discussed with the client and questions regarding fees, diagnosis, and treatment plan were discussed. I have assessed the parent's or guardian's mental capacity and found her or him capable of giving an informed consent at this time.

Date and Initial of Therapist: _____.

Consent to Feed my Child During Therapy

Child's Name: _____

Child's Birth date: _____

I, _____, authorize _____

to provide food to my child to eat during the course of psychotherapy. I understand that this practice may or may not be regularly followed.

_____ My child has no food allergies.

_____ My child is allergic to the following foods:

_____

_____

_____

I agree not to hold the therapist responsible for any allergic reaction my child has to any foods not listed above, or for the consequences of other mishaps that it can be shown that common and reasonable safety precautions have been followed in preparing and serving the food, and my child's eating of the food. This agreement supplements all previous agreements.

_____ _____

Signature of Parent or Guardian Date

_____

Signature of Therapist

Permission to Photograph, Audio and/or Video Record

I, _____, authorize _____

to photograph, audio, or vide record myself and/or my child,_____

_____.

These recordings may be used for the following purposes:

Feedback to be used for therapeutic intervention _____
initial

Research purposes _____
initial

Educational purposes _____
initial

The therapist agrees to maintain anonymity of my own and my child's name.

I understand I have the right to withdraw this consent for professional use of these recordings and/or to request their destruction (in writing) at any time. I hold the therapist harmless from any damage that might result from appropriate professional use of the recordings prior to my withdrawal of consent.

Further, I have discussed this request with the therapist and asked questions and/or sought counsel or a trusted advisor's help if there were further concerns.

Parent's Signature _____Date _____

Therapist's Signature _____Date _____

Informed Consent for Treating Children when Parents are Separated or Divorced

I. To the Parent(s):

Thank you for entrusting me with the psychological care of your child. My role is to help your child develop the coping skills needed to handle the powerful forces at work in his/her life, both now and into the future. I understand that parents' worst fears are that their child will be either clinically mistreated or that I will somehow "side" with one parent at the expense of the other (and that I will not be receptive to the input of that other parent). These fears are a part of the forces at work in the child's life and the ways they are handled can "make or break" a child's treatment.

In order to increase the chances that my work with your child will be the best it can be, I have addressed some of these concerns in writing. I will be happy to discuss any of this material with you at any time, but it's very important that you acknowledge having read and understood this document before I begin to see your child.

Professional Ethics and State law require that I try my best to work with both parents of children I see, whenever possible, so I make effort to contact both parents and to document any reasons for working only with one parent, along with the steps I am taking to involve the other parent. I normally require that both parents sign an authorization to treat their child, even if one does not have physical (or even legal) custody. The law also gives both parents reasonable expectations for information from me about their child's progress or lack of it. The law grants me the right to withhold information that I believe will result in damage to my professional relationship with the child or will place the child in physical or emotional danger, if disclosed.

Professional values suggest that even young children are entitled to expect that their communications to me will be confidential and the law suggests that they may actually be able to prevent information they share with me from disclosure in legal settings (that is, children have been able to "assert privilege" in certain situations). Courts seem to differ about this issue, with some considering a child's age/maturity level in making these decisions.

For these reasons, I ask parents to allow me to share only what I am required by law to share—circumstances when a child is behaving in ways that endanger himself/herself, others or property and information that a child wishes discussed with parents. I ask that parents help me make therapy a "safe" place for children to learn coping skills by not applying pressure of one form or another to influence the treatment process or to move it in one direction or another. I do want parents to keep me informed of what they see happening in their child's life, but communications by parents do not carry guarantees of confidentiality. I can and do share parent communications with children, taking their ages and maturity levels into consideration.

I also want parents to understand that there are two requests that I cannot grant, as doing so would endanger the safety of the child's therapy: I do not confer with attorneys for either side in a divorce or custody dispute (nor do I hold lengthy conferences with one parent that I would not hold with the other parent); and I do not write letters or make statements about which custody or visitation arrangements I believe to be in the "best interests of the child." These types of discussions and comments are appropriate for formal forensic evaluators who are charged with the responsibility to thoroughly evaluate a child's family relationships and make recommendations to the courts. My job is to

describe and treat children's symptoms with a goal of increasing their capacity to cope with the forces active in their lives. I may choose not to confer with a forensic evaluator appointed by the court to make recommendations about visitation/custody. I can and will confer with a child's own attorney, if one has been retained or appointed, or a child's legal guardian, if one has been appointed.)

However, there is no doubt but that parents do have the capacity, with enough legal pressure, to force me to disclose information (verbal and/or written) to the courts, even when I think it would be better for their children if they did not involve me in this way. I will try to be as clear with your child as possible as to the limits of confidentiality and to the issue of privilege as regards the things s/he might share with me. This clarity might result in your child being less open with me than if there were absolute confidentiality and privilege, but we live in a real world and understanding these issues is a part of the very coping skills I will try to teach to your child.

One final thought: in many cases where children are caught in high conflict divorce/custody situations, the conflict between the parents results in demands that treatment be discontinued with one clinician and that another one be sought to continue the child's care. Sometimes there are good reasons for changing clinicians—sometimes not. In any case, my general policy is that when either parent is dissatisfied enough to demand that I stop providing services to their child, I will actively consider transfer and will request that both parents allow for a transition that is smooth and professional and thus least damaging to the child.

I have read and understood this agreement:

Parent Name:_____

Parent Signature: _____

Date: _____

II. To the Child (and presented in language the child can understand):

Your parent(s) have asked me to help you learn to cope with the things that are happening in your life as they struggle with their relationships with you and with each other. I have asked them to do their best to allow us to keep our meetings private and safe—to ask no questions, to allow me to work with both of your parents, and to respect your needs for privacy.

I want you to understand that I know how hard it can be for kids to be going through the part of life you are facing. Parents have very strong fears about how their kids will be impacted by divorce and custody conflicts. Each is afraid that their child will misunderstand them, be wrongly informed about them or be guided away from them. These fears are among the strongest feelings that people can have and I have no doubts but that the power of these feelings is strong enough to make it hard for us to be sure that we have the safety and privacy for you to learn the coping skills I'd like to teach you.

You need to know that the general rule about counseling and therapy is that you can expect that I will do my best to keep the things you say to me private. Even in court, you can ask a judge to prevent me from talking or sharing records about things you want to keep between us. However, the judge won't always agree with you or with me. There are times when judges require counselors or therapists to speak or share records about things that children don't want to be known, and understanding this allows you to think about what you tell me and how you tell it to me.

You can expect that there are some things that I will definitely share with others—things that involve protecting you if you are doing things that pose a danger to yourself, others (and, if you destroy property, I won't be able keep that private if it gets you into legal trouble). In these situations, the law is clear that your privacy isn't as important as your safety or the safety of others. I am also required to report reasonable suspicions of child abuse.

Finally, there may come a time when one of your parents becomes distressed enough or concerned enough about your counseling or therapy with me that they insist that we stop working together. Except under the most unusual circumstances, if things get that serious, we will have to consider looking for a different counselor or therapist for you, even if we both feel strongly that we work well together. It isn't so much that I would be too upset about being criticized by whichever parent wanted us to stop seeing each other—it's that parents' feelings about these things are so strong that we would probably wind up talking about your parent more than we would about you—and you are the one who really counts when it comes to your own counseling or therapy sessions.

If you have an attorney that represents you—or a court-appointed guardian—I will be glad to speak with him/her and will discuss anything that I might say with you first. I will try my best not to speak with attorneys who represent either of your parents and I will let you know when either your parents or one of their attorneys contacts me so we can decide what to do.

I am so sorry that things are difficult and I want you to know that I will work very hard to make our work together as productive and safe for you as I can.

Patient Name: _____

Patient Signature: _____

Date: _____

Caregiver's Authorization Affidavit

Use of this affidavit is authorized by Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code.

Instructions: Completion of items 1-4 and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. Completion of items 5-8 is additionally required to authorize any other medical care. Print clearly.

The minor named below lives in my home and I am 18 years of age or older.

1. Name of minor: _____.
2. Minor's birth date: _____.
3. My name (adult giving authorization): _____.
4. My home address: _____.

_____.

_____.

5. ( ) I am a grandparent, aunt, uncle, or other qualified relative of the minor (see back of this form for a definition of "qualified relative").
6. Check one or both (for example, if one parent was advised and the other cannot be located):

( ) I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care, and have received no objection.

( ) I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time, to notify them of my intended authorization.

7. My date of birth: _____.

8. My California's driver's license or identification card number: _____.

Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signed: _____ Date: _____

Psychotherapy Client Questionnaire

Name: _____ Date: _____

REFERRED BY:

Name: _____ Phone#: _____

Address: _____

May I inform this person that you have consulted with me? _____

_____
Your Signature

CONFIDENTIALITY STATEMENT:

State law and professional ethics require therapists to maintain confidentiality except for the following situations:

1. If there is suspected child abuse, elder abuse, or dependent adult abuse.

2. "Tarasoff" and “Ewing” situations in which serious threat to a reasonably well-identified victim is communicated to the therapist.

3. When threat to injure or kill oneself is communicated to the therapist.

4. If you are required to sign a release of medical records by your medical insurance.

5. If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. **Think carefully**

and consult with an attorney before you sign away your rights. We can discuss some foreseeable possibilities together.

6. Clients being seen in couple, family, and group work are obligated legally to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in your treatment process. Secrets cannot be kept by the therapist from others involved in your treatment process.

7. I may at times consult with professional colleagues about our work without asking permission, but your identity will be disguised.

8. My personal secretary and office manager have access to locked and coded records but are legally charged with confidentiality.

9. Clients under 18 do not have full confidentiality from their parents.

10. It is also important to be aware of other potential limits to confidentiality that include the following:

- All records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances. Most records are stored in locked files but some are stored in secured electronic devices.
- Cell phones, portable phones, faxes, and e-mails are used on some occasions.
- All electronic communication compromises your confidentiality.

1. GENERAL

A. Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Fax: _____ E-Mail: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

B. What is your present living situation? ____

_____

C. Names and ages of children

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

D. Give a short history of your closest interpersonal relationships:

_____

_____

_____

_____

_____

_____

Education: _____

Occupation: _____

Currently working: _____

What is your present job situation? _____

_____

2. PROBLEM AREA

A. State in your own words the nature and history of your chief complaint:

_____

_____

_____

B. Present interests, hobbies, activities:_____

_____

_____

_____

C. How is most of your free time occupied?

_____

_____

_____

_____

_____

D. What are your life goals?

_____

_____

_____

_____

_____

E. What are your five greatest fears?

1._____

2._____

3._____

4._____

5._____

3. FAMILY HISTORY

A. Father's name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

_____

Your age at time of father's death: _____

Give a description of your father's personality:

_____

_____

_____

_____

_____

_____

_____

_____

B. Mother's name: _____

Age: _____ Health: _____

If deceased, age and cause of death: _____

_____

Your age at time of mother's death: _____

Give a description of your mother's personality:

_____

_____

_____

_____

_____

_____

_____

C. Brothers/Sisters (Names, sex, age, and something about each):

[Are there significant others from your growing up years?]

_____

_____

_____

_____

_____

_____

_____

D. Who are the most important people in your life? Describe.

_____

_____

_____

_____

Previous Medical, Psychiatric, and Psychotherapy Contacts

E. Have you ever been in psychotherapy before?_____

If yes, when? _____

May I contact your previous therapist(s)? _____

Therapist:_____

Address: _____

Phone: _____

Therapist: _____

Address:_____

Phone: _____

F. Have you ever been hospitalized for an emotional problem?

If yes, when, where, and how long?_____

_____

If yes, when, where, and how long?_____

_____

G. Have you ever made a suicide attempt? If yes, describe it, when, and the circumstances leading up to the attempt.

_____

_____

_____

_____

H. Have any close relatives been treated for psychiatric problems?

If yes, please specify:_____

_____

_____

I. Has any relative of yours committed suicide?

If yes, please specify:_____

_____

_____

J. Give details of all forms of abuse you were subject to in childhood (neglect, verbal violence, sexual).

_____

_____

_____

_____

_____

_____

K. Give a brief history of any litigation you have been involved in regarding child custody, divorce, liability, or medical malpractice.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

4. SELF-DESCRIPTION

Give a word-picture of yourself. Describe yourself in terms of how you presently feel and see yourself (include both negatives and positives):

_____

_____

_____

_____

_____

_____

5. MEDICAL HISTORY

A. Have you had any of these childhood illnesses?

	NO	YES	DON'T KNOW
Measles	___	___	_____
Mumps	___	___	_____
Whooping cough	___	___	_____
Chicken pox	___	___	_____
Rheumatic fever	___	___	_____
Rubella (German measles)	___	___	_____

Please list all medical hospitalizations and operations. Give diagnoses and dates:

_____

_____

_____

B. Have you ever suffered from any of the following illnesses?

	NO	YES	DATE OF ONSET
Cancer	___	___	_____
TB	___	___	_____
Diabetes	___	___	_____
Thyroid trouble	___	___	_____
Kidney trouble	___	___	_____
High blood pressure	___	___	_____

Eye trouble	___	___	_____
Heart trouble	___	___	_____
Neurological disease	___	___	_____
Ulcers	___	___	_____
Head injury	___	___	_____
D.T.'s	___	___	_____
Allergies	___	___	_____

List all allergies: _____

_____

Any other serious illnesses? _____

C. Family History

Have any of your blood relatives suffered from any of the illnesses listed above? If yes, please specify ailment and relative:

_____

_____

_____

Any other serious illness? _____

D. Drug/Medication History

Because many drugs (legal and illegal) have psychological effects, it is important for me to know what drugs you are *currently* taking and/or *have taken in the past*. This information will remain strictly confidential, but it is very important for me to know before you begin therapy so that an accurate assessment of your problem and situation

can be made. Please list *all* legally prescribed and illegal drugs ever used (past or present) and describe how often you use them and what effects you seek:

_____

_____

_____

_____

_____

Have any of these drugs been prescribed by a physician?

Yes _____ No _____ If so, which drugs and for what reason?

_____

E. Nutrition

Is your diet unusual in any way? Yes _____ No _____

If so, how? _____

_____

F. Symptoms

Check any of the following symptoms that apply to you at this time. Also indicate when any of these symptoms have applied to you in the past.

Hair falling out	_____	Fainting spells	_____
Weight gain	_____	Difficulty sleeping	_____
Fatigue	_____	Drinking too much fluid	_____
Constipation	_____	Blurred vision	_____
Dry skin	_____	Deafness	_____
Weakness	_____	Ringing in ears	_____
Weight loss	_____	Chest pain	_____
Tremor	_____	Shortness of breath	_____

Big appetite	_____	Tingling of hands or feet	_____
Fast heart beat	_____	Ankle swelling	_____
Diarrhea	_____	Indigestion	_____
Poor appetite	_____	Nausea or vomiting	_____
Headaches	_____	Urinary difficulties	_____
Dizziness	_____	Problems with sexual organs	_____

G. Menstrual History, Issues, or Problems:_____

_____

_____

_____

_____

H. Smoking and Drinking

Do you smoke (anything)? _____ What? _____How much? _____

Frequency? _____Do you drink alcohol? _____ If

yes, how much? _____What happens to you when you smoke or drink, that is,

what does it do for you?_____

_____

Describe any physical symptoms at all that you have when you smoke or drink.

I. What kind, and how much physical exercise do you get?

_____

_____

J. Describe the spiritual/religious aspects of your life:

_____

_____

_____

_____

K. Have you ever been hypnotized? If so, for what and what were the results?

_____

_____

_____

_____

L. Have you ever been on worker's comp or disability? For what, how long, results?

_____

_____

_____

_____

M. In case of emergency, please notify one of the following three people: May I have your permission to inform one or all of these people if you are ever in danger?

Yes _____ No _____

1.

_____

Name	Daytime	Evening
Address	Phone	Phone

2.

_____

Name	Daytime	Evening
Address	Phone	Phone

3.

_____

Name	Daytime	Evening
Address	Phone	Phone

This questionnaire supplements previous informed consents.

_____ _____

Your Signature Date

_____ _____

Your Signature Date

For Therapist Use Only!

Diagnostic Impressions: _____ Date _____

_____

_____

Treatment Plan:_____Date _____

_____

_____

_____

Referrals:

_____ Date _____

_____ Date _____

Informed Consent for a Visitor in a Psychotherapy Consultation

I, _____, understand that if I invite a third person to be present during a session with my psychotherapy consultant that my confidentiality is automatically compromised. I request to do so with the understanding that my therapist will use discretion but cannot promise absolute confidentiality. This agreement supplements previous informed consents.

_____ _____
Signature Date

I, _____, understand that I am being invited as a guest to attend a session with the above person's therapist. I further understand that the therapist works as a confidential agent for this person and cannot grant me confidentiality. The therapist is not free to divulge confidential information to me.

_____ _____
Signature Date

Informed Consent for Someone Other Than the Client to Assume Responsibility for Payment for Psychotherapy Services

I _____ consent to pay for psychotherapy
(Print name of payer) services for

_____.
(Print name of client) (Date)

I understand the following terms apply to this agreement.

1. Payment will be made ***at the time that service is provided unless otherwise agreed on.***

2. The fee for psychotherapy, psychological testing and interpretation, consultation, legal work arising as a result of work, letter or report writing is $_____ per 45-minute session or block of time unless otherwise specified.

3. Services will be terminated if payment is not made as agreed to by this consent.

4. Consent to assume financial responsibility for these services does not entitle the third-party payer to any interview or phone contact with the therapist or access to any confidential information that is shared within the therapeutic relationship.

5. A bill will be provided suitable for presenting to your insurance carrier for possible reimbursement.

I understand that I am financially obligated for the fees described until I revoke (in writing) this commitment.

_____ _____

Signature of Client Date

This agreement supplements previous informed consents.

Informed Consent for Telephone, Electronic, and Mail Contact

Ordinary privacy precautions such as voice scramblers, pin codes, voice mail boxes, and locked fax, mail, and computer rooms are by no means foolproof, so that ***your confidentiality is always compromised*** when communicating by electronic devices or mail. Nor is deletion or shredding of private material a totally safe means of disposal, so that you are always at risk of breaches in confidentiality when electronic or mail communication of any type is used for private information. Your use of such means of communication with your therapist, consultant, tutor, or supervisor constitutes implied consent for reciprocal use of electronic and mail communication as well.

It is the consensus of mental health professionals that reliable and valid psychotherapy, consultation, tutoring, and supervision are always conducted in a face-to-face setting, so that nonverbal communications can be taken into consideration. Body language, voice tone, pacing, emotional overtones, eye contact, and other variables are an important part of counseling or psychotherapeutically oriented professional services. However, there may be times or circumstances under which telephone, e-mail, postal, or other kinds of communication may have a limited value, such as:

1. Brief, between-session contact calls, e-mail, or mail messages.

2. Long distance communication when either party is out of town or otherwise unavailable.

3. Long distance communication for a limited period when therapy seems near its natural termination and either party relocates, making regular standard sessions

impossible. Electronic communication is always incomplete without standard, agreed-upon, and periodic face-to-face contact.

4. Limited long distance consultation, supervision, tutoring, or assessment may be appropriate when specialty or expertise is an issue. However, considerations of reliability and validity without regular face-to-face contact necessarily limit the kinds of interventions the consultant or tutor can make to (1) general questions about the client's concerns, (2) general theoretical considerations or advice, and (3) recommendations as to what kinds of professional consultation to seek locally.

I am aware of the limited validity and reliability of telephone and other kinds of electronic and mail communication as suggested above. I am further aware that I am not guaranteed confidentiality when I contact or receive such contacts from my therapist, consultant, tutor, or supervisor. I understand that the purposes for engaging in telephone, electronic, or mail communication must be limited in scope and time and that the validity and reliability of information given and received is necessarily limited. This consent supplements previous informed consent agreements.

_____ _____

Client Date Professional Date

Informed Consent for Long-Term Psychotherapy Regarding a Case Monitor, Medical Care, and Termination Plans

[Also for Use When There is a History of Trauma]

Psychotherapy that lasts for more than twenty sessions or six months necessarily involves an ongoing relationship between you and your therapist. One of the purposes of long-term, intensive psychotherapy is to allow your past emotional patterns to emerge and to be understood as they affect current relationships, particularly the therapeutic relationship. If there is the possibility that early or deep trauma of any kind affected your development, then as a part of your therapy you may need to review or to reexperience the emotions that were attached to that trauma.

Experience with revived memories of early abuse, deprivation, and trauma tells us that these memories are usually confusing, frightening, and/or upsetting. Experience in psychotherapy further tells us that such early memories are not usually recorded only in ordinary recollections, pictures of the events, or stories, but *in the ways we experience relationships and in various muscles and tissues of our bodies*. Thus, when these memories emerge in the here and now to be looked at they will be manifest in the ways you experience your therapist and/or the ways you experience your body and mind in reaction to therapy or to the therapeutic relationship.

There are three main dangers of intensive, long-term, relational psychotherapy:

1. You may begin to experience your therapist as somehow frightening, dangerous, neglectful, or not "on your side" in some way in the therapy process.

2. You may experience body reactions that represent early memories—such as agitation, distress, apathy, addictions, depression, eating and sleeping difficulties,

confusion, suspiciousness, or other physical symptoms intruding into your life in various ways.

3. You may feel a strong urge to flee, emotionally or physically, from your therapy so as to avoid further emergence of bad memories or negative experiences.

Psychotherapists have developed standard ways of addressing these three potential dangers:

1. There may come a time when your confidence in your therapist or in the therapeutic process begins to get shaky. It is important that you first bring this up with your therapist and then, if your concerns continue, to arrange with him or her to seek out a third-party professional case monitor or consultant with whom to discuss your misgivings. Your therapist will help you locate a mental health professional who is familiar with this kind of work and who can listen carefully to what problems are coming up with your therapist or with the therapy process and make appropriate suggestions and recommendations. If your therapist at any time believes your emotional reactions are threatening to you or to your therapy in any way, he or she will insist that you immediately consult a mutually agreed-upon case monitor.

2. An increase in any physical symptoms or adverse emotional reactions during the course of long-term psychotherapy usually signals the emergence of early traumatic memories. For your well-being and safety, it may be essential for you to have immediate medical and/or psychiatric evaluation and to remain under the care of a physician for a period of time. If your therapist at any time feels that the physical or mental reactions

emerging in the course of treatment may potentially endanger you in any way, he or she will insist that you go immediately for medical and/or psychiatric consultation.

3. Should you wish to terminate treatment before you and your therapist mutually agree upon a beneficial time, it may be that you are unconsciously wanting to avoid the emergence of long-hidden traumatic memories. For example, you may experience your therapist as somehow failing you, as repeating previous insults or abuse to you, or as not being interested in you, not being emotionally available, not understanding you, or not liking you. You may then abruptly want to stop seeing your therapist in order to avoid the emotional pain and/or perceived dangers of dealing with these issues. Your first remedy would likely be to consult a mutually agreed-upon case monitor (as specified in item 1, above) in order to discuss the issues coming up with your therapist or your therapy process. A part of this consultation will be that your therapist and case monitor will communicate with each other about the relevant issues. Additionally, it is of crucial importance that you be willing to continue at least five to ten therapy sessions so that you, your therapist, and your case monitor can adequately discuss your reasons for wanting to stop therapy and try to reach a joint understanding of what these reasons may mean to you and to your ongoing therapy process. If your therapist feels your decision to terminate therapy is abrupt or may be related to the revival of early traumatic memories, he or she may, in your best interest, insist that you consult a case monitor and then continue for a series of five to ten additional sessions before terminating.

Informed Consent Agreement

I have read the above considerations for entering into long-term, in-depth relational psychotherapy. I understand that certain dangers may be expected to appear

over time in relational therapy especially when there is a history of past trauma. I have discussed the dangers and the usual safeguards listed above with my therapist so that I understand them. If any of the above conditions occur—(1) the loss of confidence in the therapy or the therapist, (2) the emergence or increase of physical or mental symptoms, or (3) the wish to terminate before a mutually agreed-upon time—**I agree to abide by the three safeguards listed above, that is (1) to consult with a third-party professional case monitor, (2) to consult with a medical/psychiatric practitioner, and/or (3) to attend five to ten regular termination sessions to discuss the impasse fully.**

I further understand that this informed consent and other written requests that my therapist may make from time to time pertaining to my well-being and safety must be agreed upon in order to enter further into or to continue long-term psychotherapy. Failure to comply with any requirements that are designed to safeguard me and my therapy process will be grounds for my therapist to give me a five to ten sessions notice of termination. This agreement supplements previous informed consents.

_____

Client Signed Date

_____

Therapist Signed Date

Informed Consent

Regarding Limited Physical Contact during Psychotherapy

I, _____, hereby grant permission to my therapist to engage in limited and token forms of physical contact with me as a part of our ongoing psychotherapy process.

I understand that the purpose of therapeutic touching is to actualize for study, in concrete physical forms, certain basic aspects of human contact that I may have been deprived of or that may have been distorted in my personal development.

I understand that the purpose of therapeutic touching is not for gratification of physical longings, nor for providing physical comfort or support. Rather, the specific forms and times of the limited physical therapeutic contact are aimed toward understanding issues around the approach to, the achievement of, the sustaining of, and/or the breaking off of human emotional contact.

I understand that limited forms of physical contact such as handshakes, "A.A. type" hugs (Alcoholics Anonymous bear hugs), occasional hand holding, and other token physical gestures are not uncommon as a part of the interpersonal process of psychotherapy. However, other forms of touching are more rare and need to be clearly understood by both parties and discussed in terms of their possible meanings.

I understand that many professional psychotherapists believe that physical contact of any sort is inappropriate because it fails to encourage verbalization and symbolization of exactly what meanings might be implicit in the physical touch.

I understand that sexual touching of any type is unethical, illegal, and never a part of professional psychotherapy.

I understand that many aspects of the psychotherapeutic process, including the possible value of limited physical contact, cannot be fully established as clearly beneficial on a scientific basis. But I also understand that physical contact has many values in human relationships and that to categorically exclude it from the psychotherapeutic relationship may be detrimental to my therapeutic process when the critical focus for study needs to be around concrete and personal experiences of meaningful interpersonal contact.

I HEREBY AGREE THAT SHOULD I HAVE ANY MISGIVINGS, DOUBTS, OR NEGATIVE REACTIONS to therapeutic physical contact or to the anticipation of such, I will immediately discuss my concerns with my therapist.

If for any reason I experience concerns that I am reluctant to discuss directly with my therapist, or if I feel unsatisfied with our discussion, I HEREBY AGREE TO SEEK IMMEDIATE THIRD-PARTY PROFESSIONAL CONSULTATION FROM A LICENSED PSYCHOTHERAPIST MUTUALLY AGREED UPON BY MY THERAPIST AND MYSELF. This part of the agreement is to ensure that no misunderstandings or uncomfortable feelings arise as a result of physical contact or the anticipation of therapeutic physical touching.

I understand that I may at any time choose to discontinue this permission by a mutual exchange of written acknowledgments indicating that permission for therapeutic physical contact is revoked.

I HAVE CAREFULLY READ ALL OF THE ABOVE PROVISIONS AND HAVE DISCUSSED THEM WITH MY THERAPIST. ANY QUESTIONS OR

MISGIVINGS I HAVE ARE WRITTEN IN THE SPACE PROVIDED BELOW. This agreement supplements previous informed consents.

SPECIFIC QUESTIONS, MISGIVINGS, AND CONCERNS:

_____ _____

Client Date

_____ _____

Therapist Date

ADDITIONAL REQUESTS:

_____

Request Initial Date

_____

Request Initial Date

Group Therapy Informed Consent

Welcome to a new experience in self-knowledge!

It is important to be clear about the nature of group therapy. Attached are informational materials which seek to explain many aspects of group therapy and the therapeutic relationship. Read them carefully and bring up any questions that you may have so that we can discuss them. Feel free to bring up questions in individual or group sessions. Then sign below so we will have in our records that you have received, read, and questioned with me the information contained.

About the Relationship with the Therapist(s)

Because of the nature of psychotherapy, the therapeutic relationship has to be different from most relationships. It may differ in how long it lasts, in the topics we discuss, or in the goals of our relationship. It must also be limited to the relationship of therapist and client only. If we were to interact in any other ways, we would then have a "dual relationship". Therapy professions have rules against such relationships to protect us both.

- We cannot be your supervisor, teacher, or evaluator.
- We cannot be a therapist to our own relatives, friends (or the relatives of friends), people we know socially, or business contacts. we cannot have any other kind of business relationship with you besides the therapy itself.
- We cannot give legal, medical, financial, or any other type of professional advice.
- We cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client.

There are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions. A therapist offers you choices and helps you consider what is best for you.

You should also know that therapists are required to keep the identity of their clients confidential. Therefore, if you have any particular preferences about public meetings, let us know, otherwise we may ignore you when we meet in a public place. We must decline to attend your family's gatherings if you invite us. Lastly, when our therapy is completed, we will not be able to socialize with you like your other friends. In sum, our duty as therapist is to care for you and our other clients, but only in the professional role of therapist. We are not permitted to give or to receive gifts from clients except tokens with personal meaning to the therapy process.

Agreement for Group Therapy

As a group member, I have rights and benefits as well as duties, and I understand that some of them are described in this agreement. This agreement is a supplement to the Informed Consent, I have already signed.

This group will meet _____. The fee is $ _____ per month unless otherwise arranged. I agree to pay this fee even for group meetings I do not attend, unless other arrangements are agreed upon in advance. Fees will be billed at the end of the month and due in full by the 10th of the following month.

The purpose of this group is to provide me with the opportunity to work on the following goals:

1. _____

_____

2._____

_____

3. _____

_____

I agree to work in this group. This means openly talking about my thoughts and feelings, honestly reporting my behaviors, and exchanging helpful feedback with other members of the group.

I will do my best to attend all meetings of this group even if I do not always feel like it. If I cannot attend, I will tell the group (at the beginning of the meeting) if possible, a week in advance. Or, if it is an emergency, I will call the leader as soon as I know I cannot attend. If I decide not to go on with the group, I will discuss my reasons with the group and **I will give 4 weeks' notice to the group so everyone will have an opportunity for closure**.

I understand that this group experience is not a replacement for individual therapy. If issues arise that are not suitable for the group's process, I may benefit from individual therapy sessions, for which I will have to pay separately.

With full understanding of the need for confidentiality (that is, privacy) for all group members, I accept these rules:

1. We will use first names. Other information (such phone numbers) can only be exchanged on a person by person basis. Do not give personal information about others out to anyone.
2. We will permit no children, spouses, or other visitors in our sessions.
2. We will not permit any kind of recordings of our sessions, even by our members or leader.
3. I promise not to tell anyone outside the group about any of the problems presented by any group member as this might be identifiable.
4. I understand and agree that if I break rules 1-4, I will be asked to leave the group, and
5. I understand that may also face a possible lawsuit from others who feel their confidentiality has been breached.
6. I understand that the leader will keep a record of group meetings and that this record will only contain first names of members.

I understand that the other members of the group are not therapists and that they are not obligated to maintain the same ethics and laws that the therapist must work under. I understand that I cannot be absolutely certain that they will always keep what I say in the group confidential even though every group members has agreed to confidentiality.

I agree that any and all contacts with other group members will be kept potentially reportable in the group forum—that is, no secrets from the therapist(s) or from the group in the interest of everyone's therapeutic process. I understand that the therapist cannot

promise confidentiality from other group members regarding information shared in individual sessions. Rather, the therapist promises discretion. The reason for these two provisions is to maintain a robust therapeutic process for everyone. The minute secrets begin to develop, the full emotional sharing required to facilitate everyone's therapy diminishes.

Social and/or business contacts that go beyond mutually contributing to each others relational growth create complications and therefore are discouraged.

I have read the attached informational materials describing the possibilities of group therapy and how I can best use it as a resource for my growth and development. I agree to abide by the rules and provisions above and to discuss any questions and misgivings I may have at present or in the future with the therapist(s) and/or other group members. This agreement supplements any previous informed consents.

_____

Print Name Signature Date

We have discussed the above issues with the client. Our observations of this person's behavior and responses indicate that this person understands the rules and provisions of group therapy as set out above and is competent to give informed and willing consent at this time.

_____

Signature of Therapist Date

I agree to the provisions of the group as set forth herein

_____

Signature of Co-Therapist Date

Expert Witness Agreement

Expertise Determination and Availability

In order to determine whether my expertise and availability fit the demands of the case I need to review the basic documents and charge a flat document-review fee of $_____to be paid at the time of document submission. I am a (profession) specializing in issues related to the psychotherapy process--especially dual relationships, transference and countertransference, standards of practice, and accusations against therapists.

Hourly Fee for Services

Forensic work necessitates my setting aside other previously planned work, so I must charge $_____per clock hour for all preparation and travel time portal-to-portal from my home or office. Work conducted at locations other than my office will be billed at $_____ per hour. Outside of (my county) I must travel the night before, so hotel, meals, and other necessary travel expenses are reimbursable.

On Call or Cancellation

To be "on call" for court I charge a flat fee of $_____whether or not I am called—plus usual hourly fees and travel expenses, *all to be paid at the time of scheduling the event*. All conference, deposition, and court time that is scheduled by the responsible party will be charged unless there is fourteen days cancellation notice.

Payment of Fees

All fees are deducted from a retainer deposited in advance which will vary from $_____to $_____depending on the anticipated needs of the case. *No work can be done nor scheduled dates confirmed without fees being paid in advance.*

Signature of Acceptance

As the person financially responsible for engaging _____for expert witness work, I hereby indicate my acceptance of the working conditions and arrangements for fees as outlined herein.

_____Date_____

Representing:_____

Name(s) of the Case(s) Involved:

_____

SECTION TWO

RECORD-KEEPING FORMS

Chart Progress Notes (Form I)

Client's Name: _____ Date Session #_____

General Content of Session:

Interventions and Responses:

Changing Goals and Progress: (DSM?, GAF?)

Transference–Countertransference Themes, Reactions, and Processes:

Check if Applicable:

_____Suicidal risk
_____Homicide risk
_____Diminished capacities
_____Mandated report
_____Follow-ups
_____Referrals
_____New issues
_____Demonstrates improvement

Explain Items Checked:

Therapist's Signature: _____ Supervisor's Signature: _____

Date: _____ Date:_____

Chart Progress Notes (Form II)

Patient Name:_____ ID# _____ Date:_____
Current Symptoms:

PATIENT PROGRESS NOTES

__Poor Sleep
__Poor appetite
__Increased appetite
__Weakness
__Decreased sex drive
__Hyperventilation
__Palpitations
__Depression
__Headaches
__Cries easily
__Indecisiveness
__Work problems
__Irritability
__Personality Changes
__Constipation
__Diarrhea
__Weight loss
__Suspiciousness
__Hyperventilation
__Fearfulness
__Lack of Interest
__Feelings of guilt
__Family problems
__Tinnitus
__Physical complaints
__Inferiority feelings
__Hearing voices
__Seeing things
__Suspiciousness
__Anger
__Fearfulness
__Phobias
__Social withdrawal
__Dry mouth
__Nightmares
__Dizziness
__Tachycardia
__Suicidal Ideation
__Blurred vision
__Tremulousness
__Avoiding people
__Unable to have fun
__Irritability
__Excessive worrying
__Tension
Numbness
__Sexual problems
__Nausea

Other_____
_____

Current Medications:

Medication Name Dosage How Taken Date Started/Stopped

_____
_____
_____

Medication Changes: _____Side Effects:_____

Mental Status:

Orientation:__Person:__Place:__Time:__Situation:_____
_____

Speech: __Lucid __Fragmented __Disorganized __Blunted mute
Mood: __Appropriate __Inappropriate __Depressed __Anxious __Angry __Flat __Apathetic __Labile __Constricted
Other_____
Thought Process: __Coherent __Goal Directed __Rational __loose __Other
Thought Content: __Relevant __Expansive __Grandiose __Suicidal __Homicidal __Cognitive distortions __Auditory hallucinations __Other

Assessment: (Clinical response, functional impairments, justification for continued treatment):

_____
_____

Plan:

_____
_____

Signature _____Next Appointment _____

Chart Progress Notes (Form III)

Patient name:_____

Date of Service_____ Length of Session_____ Start_____ Stop _____

CPT: 90806/90818/90847/90853/Other_____ Diagnoses:_____

Symptoms: _____

Axis IV Psychosocial and Environmental problems addressed:

____Primary support group problems
____Social environment problems
____Physical health problems
____School/work problems
____Housing problems
____Self-care problems
____Economic stressors
____Current victimization
____Other psychosocial stressors

Current GAF_____; Highest GAF this year_____.

Current Meds._____.

Risk issues assessed_____.

Consultations:_____.

Tx Plan_____.

Informed consent issues discussed this session:_____

_____

_____

_____

(Signature)_____

Confidential Psychotherapy Note

Patient Name _____Date_____

Disclosures this session_____

_____

Interventions this session _____

_____

_____

Patient Comments/Behaviors_____

_____

_____

_____

Homework_____

Signature_____

Note: Under the 1996 Federal Health Information Portability and Accountability Act (HIPAA) "Psychotherapy Notes" are created for the exclusive use of the treating professional and may not be subpoenaed or discovered except under rare and extreme circumstances. State laws may preempt HIPAA.

Periodic Clinical Reassessment/Review

Name:_____

Date:_____

Current Frequency:_____

Current Diagnostic Depressions:

Ongoing Treatment Goals:

Transference Themes:

Countertransference Themes:

Notable Occurrences:

Prognosis:

Other:

Treatment Summary Information Guide

California Health & Safety Code 123130 holds that a treatment summary may be prepared in lieu of a patient record, within 10 working days of the request (if a record is unduly long or a patient is recently discharged, 30 days are allowed, but the patient must be notified in writing). Summaries must include:

(1) Chief complaint or complaints including pertinent history.
(2) Findings from consultations and referrals to other health care providers.
(3) Diagnosis, where determined.
(4) Treatment plan and regimen including medications prescribed.
(5) Progress of the treatment.
(6) Prognosis including significant continuing problems or conditions.
(7) Pertinent reports of diagnostic procedures and tests and all discharge summaries.
(8) Objective findings from the most recent physical examination, such as blood pressure, weight, and actual values from routine laboratory tests.

Fees:

The health care provider may charge no more than a reasonable fee based on actual time and cost for the preparation of the summary. The cost shall be based on a computation of the actual time spent preparing the summary for availability to the patient or the patient's representative. It is the intent of the Legislature that summaries of the records be made available at the lowest possible cost to the patient.

Special Release of Confidential Psychotherapy Notes

I, _____
(Patient)
authorize _____
(Professional)

to release information as follows:

I. Specific information requested and its intended use: (to whom, for what)_____
_____

_____

II. Length of time the information will be kept before being destroyed or disposed of:
_____

(I understand that, in order to keep the information longer than the time specified, I must be notified of the extension and the specific reason for the extension, the intended use of the information during the extended time and the expected date of the destruction of the information.)

III. I understand that the information will not be used for any purpose other than its intended use.

IV. I understand that the person/entity requesting the information will destroy it and all copies of it in the person/entity's control, will cause it to be destroyed or will return it and all copies of it to me, before or immediately after the length of time specified in item II (above) has expired.

V. I have received a copy of this written request 30 days prior to sending the requested information, or I have signed a written waiver in the form of a letter submitted to the provider of healthcare ("Professional," above) waiving notification.

VI. The professional (above) is not authorized to disclose information to any other person/entity without my consent.

Name (printed): _____
Signature: _____
Date: _____

Note: Under the 1996 Federal Health Information Portability and Accountability Act (HIPAA) "Psychotherapy Notes" are created for the exclusive use of the treating professional and may not be subpoenaed or discovered except under rare and extreme circumstances. State laws may preempt HIPAA.

Letter of Request for Confidential Records

To Whom It May Concern:

Enclosed please find a release of confidential information signed by a former client/patient of yours. I would appreciate your sending me copies of all notes, summaries, tests, and other records that may be helpful in consulting with this person. A photocopy or electronic copy of this document is as valid as the original.

Yours truly,

Name: _____

Date of request: _____

Signature: _____

Release of Confidential Information for Purposes of Consultation, Research, Teaching, and Publication

I,_____, understand that the science of psychotherapy grows based upon a willingness of clients and therapists to consent to release private and confidential information for study by others.

I have read the attached manuscript of _____ pages, dated _____, titled:

_____

_____

I hereby certify that all material contained in this manuscript is thoroughly disguised with regard to the identity of myself and others. I hereby consent for the material in this manuscript to be used by _____ for consultation, research, teaching, and publication aimed at advancing the field of psychotherapy.

_____

Signed Date

Release of Protected Health Information (PHI)

Name of Client: _____

Date of Birth: _____

I hereby authorize the release and exchange of information between (therapist's name) and the following health care professional, agency, or institution:

Name: _____

Address: _____

Phone Number: _____

This authority extends to the furnishing of copies of all or any desired portions of the records pertaining to the above named client.

(therapist's name)_____ and the individual, agency, or institution named above are hereby released from all legal liability that may arise from this exchange or release of information.

I understand that I may revoke this consent at any time by informing all of the above parties in writing.

Signature _____Date _____
Patient

Signature _____Date _____
Parent or Guardian

Note: The 1996 Federal Health Information Portability and Accountability Act (HIPAA) allows with one generic release the exchange of Protected Health Information (PHI) involved in **t**reatment, **p**ayment, and health care **o**perations (TPO). Patients may request restrictions on this exchange and revoke it at any time (in writing).

Termination Summary

Client: _____Birth Date: _____

A. Reasons Treatment Sought_____
B. Diagnostic Summary_____
C. Outside Consultation Summary_____
D. Course of Treatment Summary _____
_____
_____

E. Prognosis _____

F. Main Reason for Termination
___The planned treatment was completed.
___The client refused to receive or participate in services.
___The client was unable to afford continued treatment.
___Did not pay bills on time.
___There is a planned pause in treatment.
___The client needs services not available here, and so was referred.
to: _____

G. Sources of Termination Decision
___Client initiated.
___Therapist-initiated.
___A mutual decision.
___Other
(Specify):_____
_____

H. Treatment Frequency and Duration:_____

I. Kinds of Services Rendered
___Individual psychotherapy
___Couple/Family therapy.
___Group therapy.
___Other:_____

Therapist(s) Signature: _____Date_____

Organizing Experience Worksheet

[For therapist use in considering deep transference issues and/or trauma history uses]

Client's Name _____
Date _____

1. Bring fully to mind someone you know or work with but have a hard time staying emotionally connected to. Describe this person's relationship with you.

2. How do you experience this person's connections and disconnections?
____unavailable for connection, ____quick to break connection, ___unable to sustain connection, ____gets me to break connection. **Describe briefly.**
How are connections typically made and broken?

3. Why do you think this person has a hard time connecting and holding onto connections?

4. Common Subjective Concerns of this person are:

____I feel very crazy, like falling apart or dying.
____I worry I won't be able to find you if I need you.
____If I can't hold on the way I need to, I'll die.
____I am overwhelmed by what seems easy to you.
____I need not to be pressured or rushed.
____There must be time and space for my expressions.
____I must have continuity and safety with you.
____I need to hear, see, smell, and feel your presence.
____Please be available or don't tantalize me.
____I need to have a total body experience.
____I need you to be alive to me and my concerns.
____Please respect my sense of time and space.
____Don't expect me to have more ego than I do.
____Show me in concrete ways how to hold onto you.
____Please don't crush, kill, or abuse the child inside.
____Don't agree to hold me if you intend to drop me.

____Don't assume I'm connected when I'm not.
____Please search for my sense of life inside.
____Show me how to connect with myself and you.
____(Other)_____
_____
_____
_____
_____

5. What kinds of expressions and symbols does the person use in regular self-expression that strikes you as unusual, unique, or obsessive? What ongoing or over-concern does the person have with things such as religion, food, love, relationships, work, children, illness, morals, judgements of others? **How are these symbols and concerns used to connect, avoid, or rupture connections?**

6. What kind of nonhuman imagery does the person use fairly regularly? How does the person experience mechanical, impersonal, uncontrollable, mystical, economic, political, legal, and/or supernatural forces or movements in the world that determine things? How are people and relationships experienced as powers, forces, devices, diseases, or trends to be dealt with, controlled, or avoided. How are things in the person's life experienced as governed by impersonal or inanimate forces, strange happenings, or persecutory signs? **How does the person use nonhuman imagery to connect and disconnect from people?**

7. What kinds of physical sensations, preoccupations, or symptoms are mentioned often? How are body parts, physical symptoms, and health fears in one way or another a frequent concern? This can include focus on organ functioning, weight gain and loss, food and substance use and abuse, or obsessive concern with exercise and health, digestion and evacuation, and mental and physical deterioration or disease and aging. **How are compulsive concerns with physical matters used by this person to achieve, thwart, and destroy connections?**

8. How is the person's orientation in time and space less than reliable and consistent? What kinds of regular or periodic confusions, lapses, distortions, disorientations, or inconsistencies occur? When and under what circumstances does the person seem less than

reliably and safely grounded? **How do orientation issues involved in this person's life relate to her or his connections and disconnections?**

9. What other ways have you observed that this person uses to avoid, rupture, dilute, or cut short emotional connections?

10. Describe special moments when you and this person are clearly affectively connected? What do those moments look like in terms of body involvement? What contents or kinds of events allow these special connections to occur? How are these moments lost or destroyed? How does the person change or dilute the subject, focus, or emotional impact of such connections?

11. How does it seem this person uses "projective identification" or your "countertransference" response to achieve a minimizing, an avoidance or a breaking off of contact? That is, in what ways is she or he using longstanding skills to push you away or alienate your emotionally? In what ways has this person skillfully ferreted out things in you that are easily mobilized and that can serve to disrupt the mutual emotional connection?

12. Forgetting "usual therapeutic technique," what do you think you could do or say to get this person to hold on to these special moments of emotional connection with you for a little while longer? What would it take to get her or him to stay with you a little longer?

13. What do you think would happen if you could encourage the person to stay connected longer? Be specific. In both bodies? In the emotions of two? In the sense of connection?

14. How is deep transference terror likely to manifest itself? What about countertransference terror? How will the two of you handle it?

15. As you have been considering inviting this person into more intimate relating with you what emotional reactions have you been having?

16. What body reactions have been occurring as you imagine getting closer to this person? What sorts of fears are arising for you and how are they manifest in various places in your body?

17. Why does this project seem like it just won't work? In what ways does it seem plausible?

18. What comes up for you now as you think of sharing these reactions with colleagues?[1]

[1] This form was taken from Hedges, L.E. (2000). *Terrifying Transferences: Aftershocks of Childhood Trauma*. Northvale, NJ: Jason Aronson.

SECTION THREE

INFORMED CONSENT CONTRACTS FOR SUPERVISION AND ONGOING TRAINING FOR THERAPISTS

Informed Consent Regarding Supervision, Case Consultation, Case Conference Seminars and Individual Tutorials

General Purposes

Many licensed therapists of all disciplines wish to further their understanding of themselves and how they work, thereby further developing their skills as therapists. Studying psychotherapy theory and practice is one effective way of broadening the perspectives through which therapists listen to the people who come to them for help. The psychotherapy tutorial experience aims at demonstrating with clarity and depth the varieties of transference, resistance, and countertransference situations that arise in the course of intense human relationships. The tutorial seeks to study the many types of interpretive activities that become possible as the therapeutic process unfolds and different phases of developmental experience are being presented to the therapist for consideration. Occasionally an advanced trainee who is a candidate for licensure may be admitted to a group but only with full written authorization from his or her supervisor.

The Nature of the Case Conference Seminar and Individual Tutorial

Groups of three to eight professional therapists typically meet ninety minutes weekly or biweekly on an ongoing basis. Group members take turns each week presenting some aspect of their work that they are seeking to understand more fully. Group discussion considers the therapist's presentation and the issues it raises for everyone. Once a month the group may read a notable article or book and spend the session discussing the theoretical and practical issues it raises.

Ethical constraints in a tutorial require that a therapist fully disguise the case material, meaning that the material to be discussed is necessarily partial, selected, anecdotal, or even deliberately distorted. This ethical consideration limits severely the comprehensiveness and reliability of the material to be studied. This means in general that the therapist cannot seek or expect direct advice from the group or from the tutor about the treatment. Nor are the group members free to offer advice about the treatment based upon solid familiarity with the facts. Substantive issues for discussion revolve around the case history, the development of transference and resistance, the emerging countertransference, and general issues about how the relationship is evolving and the kinds of interventions that might be useful. A few recommendations may be made: that the client be referred to a psychiatrist for evaluation for medication, hospitalization, or intensive day treatment; that a substance abuse, eating disorder, or other specialty treatment program be initiated; that action be taken regarding some form of molest or abuse; that some "Tarasoff" or "Ewing" action be taken; that educational, vocational, or other type of outside consultation be sought; that the therapist take the case for ongoing, in-depth case consultation or supervision; or that a third party case monitor be designated. All material discussed in the seminar is understood to be strictly confidential, including infractions of laws and ethics, unless a situation of mandated reporting should occur.

Some General Recommendations to Therapists

1. Brief notes should be kept on all client contacts and detailed notes kept on critical incidents and consultations. Records of all past medical, psychiatric, and psychotherapeutic treatment should be obtained for your files.

2. Transference and countertransference themes should be spelled out in the case record with cautious speculations about how those themes might affect the future relationship and what

dangers they may pose to the therapeutic relationship. Disclosures of countertransference material should be judiciously documented for therapeutic intent, content, reaction, discussion, and follow-up.

3. **All forms of physical contact should be avoided if possible.** Whenever unusual, procedures or acts are engaged in (like touching, hugging, extra sessions, or phone calls) the complete rationale needs to be carefully noted and perhaps third-party opinion sought. "A.A.-type hugs," routine handshakes, or other ritual behaviors may have many hidden transferential meanings that only later may disruptively emerge. There are many ways to work through the avoidance of these forms of contact. The therapist's willingness to engage in such unusual practices may be harmless or at times essential to the uninterrupted or undisturbed flow of the relationship as the replicated symbiotic transference unfolds.

Specific forms of concrete interpretive touching need to be well conceived and documented. But the danger is often that the therapist may be tempted to soothe, comfort, or contain some frantic or fragmented state *so that the therapist's anxiety can be lessened*. This is not generally a valid therapeutic procedure. A written informed consent for physical contact should be used.

4. In-depth third-party case consultation is increasingly becoming a safeguard against malpractice risks, especially if there is a borderline or psychotic feature or a history of severe deprivation, trauma, damage, abuse, or molest. It is now known that when the psychotic aspect of transference finally becomes mobilized, the person in analysis may well lose the capacity to distinguish what is realistic in the therapeutic relationship from the therapeutic transfer of the deep intrusive traumas of the past that are being recalled in the transference relationship. When

disturbed reality testing is encountered in the transference, the therapist may become endangered, until and unless the critical interpretive work can be accomplished.

5. An initial psychiatric consultation is recommended on all cases with significant history of trauma and/or symbiotic or organizing (psychotic) pockets so that a baseline can be established for future reference. Follow-up consults should be required from time to time to evaluate the danger of impending fragmentation that might be medically regulated and the potential advisability of hospitalization.

6. Along similar lines with high-risk cases, in-depth individual consultation sought out periodically is good policy. I would recommend a minimum of three to four hours on the same case in close sequence so the details can become known to, digested by, and carefully recorded by the consultant with recommendations that have been carefully thought out by two. Consultation with a specialist on issues about which you may feel uncertain is now an acceptable standard of care.

7. Many times it may be important to consider sending registered letters to clients when you feel strongly that a form of consultation is needed, that some aspect of case management is necessary, or when you are needing to set limits or to terminate them for any reason. When setting limits or terminating a client, be sure to state in writing your reason, give appropriate time for discussion and action, and give three appropriate (e.g., nonprofit corporation clinics, psychiatrists, government agencies, etc.) referrals. Consultation with an attorney is recommended in connection with such letters. Be sure to send by certified mail or obtain the client's signature that he or she has received the letter.

8. The American Psychological Association Insurance Trust now strongly suggests that we keep summaries of all past therapies and medical reports as well as a case history since many

critical details with malpractice implications are often not mentioned in the usual therapeutic dialogue. Periodic case summaries and a termination summary are essential.

9. If you do any type of prepaid or managed health care, be certain that your professional opinion and recommendation regarding patient care are given in writing. Do not defer your opinions to the administrative needs of the third party. You can be sued for failure to assess and recommend professionally. The third party can be sued but persons performing administrative tasks are not licensed, are generally not sued, and have little to lose by their decision or recommendation. Do not compromise your professional opinions to satisfy third-party demands; find some other way of negotiating with the potential referral source. Be clear with your clients, put problems into writing, and obtain client signatures whenever possible.

Case Conference Seminars and Individual Tutorials Contrasted with Supervision and Case Consultation

1. The case conference seminar and individual psychological tutorial represent a form of in-service training *for the practitioner*. It cannot be considered reliable case supervision or consultation on the patient's or client's behalf because as has already been mentioned, ethical constraints require that the material presented in the tutorial be condensed, selected, disguised, and perhaps even distorted so that comprehensive information cannot be provided, meaning that reliable advice is not possible.

2. Supervision in which the supervisor participates with full professional responsibility in the treatment for the purposes of statutory training is of an entirely different nature and is spelled out by state law and the training requirements of each profession and in each training setting. The client must be informed in writing of the supervisory process and sign a form of consent. For California psychologists the required ratio of supervisor hours to patient contact

hours is 1:10. Further, the supervisor must be on the premises for at least 50 percent of the time the trainee is actually seeing clients. *Client fees must be paid only to the supervisor or training clinic while the trainee works as a volunteer or paid employee of the supervisor or clinic*. Other disciplines and other locales have similar requirements, e.g., psychoanalytic training is the most stringent with a supervision-to-client hour ratio of 1:4, the four hours being with the *same* client. Only with closely defined restrictions is it possible for the supervisor to gain even close to a complete understanding of the actual treatment process and therefore to be in a position to offer reliable intervention advice.

3. Case consultation is a process in which *the consultant actually sees the client* in a professional role for assessment and or recommendations. A written report should be obtained for the treating therapist's records. Psychological testing, third-party case monitoring, and psychiatric evaluation are common types of consultation.

Summary

Dynamic psychotherapy case conferences and individual tutorials are for the benefit of the professional therapist who wants to further his or her understanding about professional issues. The best vehicle for the case conference or tutorial is the review of anecdotal case material accompanied with parallel readings. *Supervision and consultation are completely different processes* whereby no constraints are placed upon the kind of material that can be discussed, and the frequency and intensity of the contact is such as to permit valid and reliable intervention. The case conference and individual tutorials are strictly educational and personal in nature and carry no professional liability to the client on treating therapist while case consultation and supervision represent a collegial collaboration in a treatment process with shared liability.

Record Keeping and Confidentiality

Formal notes or recordings are not a regular part of case conference seminars or of the tutorial educational experience, though a log in usually kept to document which cases are discussed by whom on what date. The presenting therapist may wish to document ideas and reactions from the tutorial in his or her case notes. With unanimous group permission the presenting therapist may tape record the sessions for his or her private use. In California under the Business and Professions Code Case Conference and Tutorials generally qualify as "peer group" consultation in that professional and personal issues (countertransference) are discussed. As such a treating professional can claim privilege for the process as with group therapy.

Occasionally the tutor may request to record sessions because the case is of research interest. Any notes or recordings must be treated with absolute confidentiality by all parties concerned. Permission of the therapist (and possibly the client) should be sought before such material can be used for teaching and/or research purposes. All group members are bound by rules of professional confidentiality at all times.

Fees and Legal Costs

Case conference fees are $_____ per session and individual tutorial fees are $_____ on a regularly scheduled ongoing basis whether the learner is present or absent for the scheduled session. In the event that the tutor is ever asked or required to provide testimony of any sort on behalf of any learner, that person (or his/her insurance carrier) will be responsible for paying the tutor's regular clinical consultation fee on a portal-to-portal basis; travel, board and lodging expenses, and an additional regular fee of up to thirty hours of preparation time; and any legal fees that may be incurred for professional consultation or legal representation in the matter. Since the nature of the tutorial is educational, the content partial and anecdotal, and detailed

records are not maintained, the likelihood of required testimony seems remote. The learner may wish to claim privilege on the basis of individual and group tutorials being personal and confidential and therefore essentially a form of peer counseling.

The Nature of Individual Psychotherapy Tutorials

One-to-one tutorials in psychoanalytic theory and techniques are offered on the same basis as outlined above for groups. Regardless of what such experiences are called in various settings, in individual tutorials as in group tutorial, case material is discussed for the educational purpose of illuminating psychotherapy theory and practice but on a more personalized basis, more "tailor made" to the individual needs of the therapist. Tutorials are not to be confused with the more intense and closely collaborative work engaged in as statutory supervision with the supervision explicitly designated by the state or training agency as defined by various legal bodies and professional organizations. The tutorial represents in-service training for the therapist. The vehicle for that training experience is the review and discussion of case work. The limits and expectations of the individual tutorial experience are the same as those discussed above under case conference seminars.

What Is Dynamic Psychotherapy?

Dynamic psychotherapy originated with the work of Dr. Sigmund Freud in Vienna in the late nineteenth century. Therapy is both a way of understanding human emotions and of helping people with their relationships and their personal problems. The mature or rational self that functions more or less successfully in the real world is only a part of the total person. The more immature, irrational, or unconscious self functions silently in the background to produce various symptoms and maladaptive behaviors that often intrude into the person's social life, personal relationships, school or work activities, and physical health. In dynamic psychotherapy specific

problems are viewed in the context of the whole person. The quest for self-knowledge is seen as the most important key to changing attitudes and behavior.

Dynamic psychotherapy is based on the insight that our personalities are the result of passing through and solving relationship issues at many developmental stages. At any stage, the way we have reacted to events in our lives may have caused us to get stuck at a certain level of insight or problem solving. While we go ahead and mature satisfactorily, in many ways we may carry within us the parts that didn't have a chance to develop. We can have a mature exterior and be functioning more or less successfully, while internally we may feel vulnerable, confused, depressed, angry, afraid, and childlike. We may not feel able to bounce back from rejection, get past blocks, allow our real feelings to surface, or stay in touch with our feelings and desires. Our physical health may be compromised in many ways by emotional and relationship issues.

Dynamic psychotherapy is designed to help the client get in touch with her or his unconscious memories, feelings, and desires that are not readily available to the conscious mind. Therapy is designed to help clients of all ages understand how their unconscious feelings and thoughts affect the ways they act, react, think, feel, and relate. Whether or not therapy works depends a great deal on the client's willingness and ability to experience all relationships deeply, especially the therapeutic relationship. Each client, by expressing her or his story in whatever ways possible to someone who knows how to listen and to give new meanings back, has the opportunity to learn about herself or himself in a new way.

Dynamic psychotherapy can provide a safe place for people of whatever age to discover for themselves their own truths. It provides a unique opportunity to re-experience personal history in a new relationship, to see it in a new way, and to make connections between past and current conflicts that illuminate the way one relates to oneself and to others.

Clients are encouraged to talk about thoughts and feelings that come up about therapy or about the therapist. These feelings are important because elements of one's earliest affections and hostilities toward parents and siblings are often shifted onto the therapist and the process of therapy. This phenomenon, known as "transference," offers a rich source of understanding, for it offers the possibility for people to re-experience and re-work important feelings arising from the past with the maturity they possess in the present.

Dynamic psychotherapy is usually not a short-term therapy as it takes time to explore the complex layers of feeling and experience that make up a person's own unique relationship history. People find that their therapy easily can extend for several years but there is no prescribed length of treatment. Only the people closely involved have a sense of when personal goals have been met. When the client feels she or he has accomplished the desired goals, then a termination date can be set.

Dynamic psychotherapy aims to help people experience life more deeply, enjoy more satisfying relationships, resolve painful conflicts, and better integrate all the parts of their personalities. Perhaps its greatest potential gift is the essential freedom to change and to continue to grow in relationships.

Informed Consent Regarding Case Conference Seminars and/or Individual Psychotherapy Tutorials as Distinguished from Case Consultation and Supervision

Name: _____

Home Address: _____

Work Address: _____

Home Phone: _____ Work Phone: _____

Fax _____E-Mail _____

I understand that consultation group fees are $_____ for each 90-minute session unless otherwise arranged. I further understand that I will be responsible for paying the fee before the end of each month whether or not I can attend the sessions. The fee is subject to change occasionally.

I understand that the group is *ongoing* and meets continually except for previously announced vacations and holidays of the therapist. Should I discontinue or change groups I will give notice of at least four sessions so that group members have an opportunity to deal with the termination.

Individual tutorial fees are $_____ per 45-minute session unless otherwise arranged. If ongoing regular group or individual time is reserved, I understand that I am responsible for regularly scheduled time whether or not I am able to keep the appointment.

I understand that occasionally sessions may be recorded for research, teaching, and publication purposes with the permission of the presenter and without the right to financial remuneration. I agree to disguise at all times the identity of the client as much as possible. Tapes will be kept locked in a safe and later destroyed or given to the presenter.

I understand I may be asked to help edit the transcript of my work and that I have the right to refuse to have the material utilized for research, teaching, and publication purposes.

I have read the above description of the case conference seminar and individual tutorials as contrasted with case consultation and supervision and understand their educational purposes. I agree to abide by the ethical codes of my profession and to adhere as closely as possible to the guidelines set out herein regarding the seminar and tutorial experiences. Since participants may

share personal as well as professional information that is private, I understand that all communications may be claimed as privileged and confidential and agree to abide by all ethical and legal considerations of confidentiality.

_____

Signature Date License Number/Expiration Date

_____

Malpractice Carrier and Policy Number Expiration Date (attach face sheet)

_____

Supervisor's Name and Signature Date License Number/Expiration Date

Note: Please attach face sheet of current Malpractice Insurance

Employment Agreement for Trainees

This is an agreement entered into between _____ (licensed psychotherapist) and _____ psychotherapy trainee).

This employment agreement supplements the state laws regarding the employment of trainees and the ethics requirements of the various professions concerned. Those laws include absolute adherence to the ethical codes of each profession. The trainee will hereinafter be referred to as "employee" and the licensed psychotherapist as "employer."

1. Laws and Ethics. Employee agrees to study carefully the ethics codes of the American Psychological Association and, if training in another discipline, the codes of that discipline. Any questions will be addressed to the employer. Employee agrees absolutely to abide by all laws and ethical codes governing clinical practice while under supervision of the employer. Employee agrees to discuss immediately with employer any and all questions about or possible infractions of those codes, or questionable situations that create potential risks and/or liabilities for the employee and/or employer. Failure to do so constitutes a breach of this agreement.

Employee assumes sole personal and financial responsibility and liability for any problems and/or claims resulting from an infraction of the laws and applicable ethics codes and further indemnities the employer against any and all claims of whatever type resulting from employee's legal or ethical infractions. Any and all legal and/or outside consultation expenses resulting from or necessitated by claims of alleged infractions or the investigation thereof are to be borne by the employee. If the time spent by the employer exceeds ten hours in dealing with such claims he will be reimbursed by the employee at $_____/hour since infractions or other

activities that might lead to allegations are beyond the scope of employment and not a part of this employment agreement. All professional services are to be rendered on the employer's regular work site unless otherwise agreed upon in writing. Upon discussion of possible infractions the employer reserves the right to insist on outside clinical, ethical, and/or legal consultation at the employee's expense and/or to terminate this agreement immediately. Legal and ethical infractions by employee may be reported to her or his training institution and/or to the relevant licensing boards and ethics committees. All dual relationships with clients, ex-clients, or friends, or relatives of clients, or ex-clients that are exploitative and/or damaging, especially business, social, and sexual ones, are forbidden by law and will result in immediate termination and possible reporting to authorities. Employee agrees to maintain membership in the appropriate state professional association both to remain updated on professional issues and to have ready access to legal counsel.

2. Financial Arrangements. Employee will be treated as an "employee" under IRS laws and employer will maintain payroll records in accordance with all state and federal tax and employment laws.

Operating expenses for hiring an assistant or intern in this particular private practice setting have been determined to be approximately $_____ monthly, which includes use of office space, light clerical work, bookkeeping and accounting, and consideration for expenses involved in overseeing the work of the trainees, file management, and emergency consultation. Employee must arrange for and/or assume financial responsibility for his/her own telephone, voice mail, beeper services, and malpractice liability insurance.

Because expenses are high in private practice, the percent paid on gross receipts up to the amount of $_____ in a calendar month to the employee will only be ____% of fees collected for

services rendered. The employee will be paid _____% of all fees collected in a calendar month over that figure. Any agreed-upon supplementary hours are to be paid at the rate of $_____. Should any change in this arrangement be deemed necessary or desirable, both parties will agree and put in writing the altered terms.

Should the gross monthly income drop below the first figure above for three consecutive calendar months or average below that figure for any six-month period, the employer may need to renegotiate the arrangements, or ask for a termination for financial reasons.

All client checks must be made to the employer and the date on the check or the date actually turned into the bookkeeper (whichever is later) will determine the month to which the check is credited. All fees are to be turned in daily if possible but definitely before the weekend. Cash payments will be receipted and signed by employer. Pay periods will be roughly twice a month as arranged with the financial manager. The employee will be responsible for accurately filling out insurance forms and other bills, having the supervisor sign them, and, if appropriate, pursuing them to collection. Collection agencies or other forced collection procedures will not be used unless authorized by employer, so the employee needs to be prepared for losses of all fees not collected at the time of service.

Trainee will use informed consents in the book, *Facing the Challenge of Liability in Psychotherapy* and other forms provided by the employer in order to ensure uniformity in the practice.

3. Malpractice Insurance Coverage. The employee is responsible for working with the employer's financial manager and arranging for malpractice coverage and administrative law protection equivalent to that which the employer carries. This can be arranged under the employer's existing policy or under a separate policy so long as the financial manager deems it to

be essentially equivalent. Employee must bear the cost of this insurance directly and provide the employer ongoing proof of coverage.

4. Supervision. The employer agrees to provide one hour of face-to-face individual supervision (a standard 45-minute session) and two hours of group supervision (a standard 90-minute session) weekly. The employee must arrange to accommodate the time schedule of the employer. Extra time can be scheduled by consulting the employer's calendar several days in advance. Emergency after-hours and weekend consultation supervision coverage will be arranged according to need. If more ongoing time is deemed necessary by the employer, the financial overhead agreement will need to be revised.

5. Files and Records. All confidential files and records are and shall remain the property of the employer. The employee shall have the right to copy any and all parts of the records for his or her professional use at his or her expense. At the outset employee is responsible for providing complete copies of professional and personal files of any client brought into the practice. All laws and ethics regarding record maintenance are to be strictly maintained by both parties, with special reference to:

a. Information in writing must be given to all clients that employee is not licensed but working under the supervision of the employer and that all fees are to be paid to the employer.

b. Use of Client Information Questionnaire and Informed Consent contracts as well as supervisor's other standard file documents as required and approved by employer is necessary.

c. Original files are never to leave the employer's office under any circumstances. Copies are subject to all precautions to ensure their confidentiality. In the event materials for letter writing or evaluations need to be taken from the office, only copies may be removed and they

must be kept stored in a large self-addressed, stamped envelope marked clearly, "Confidential Medical Records, Drop in Any Mailbox."

6. Termination of Employment. Either party has the right to terminate this agreement without cause upon thirty days' written notice delivered in person or by a certified agent to the other. The supervisor may terminate the contract immediately in the event of a breach in law or ethics.

This employment agreement, along with the laws, state regulations, ethics codes, and limitations of both parties' malpractice insurance, constitutes the entire agreement between employer and employee. No other informal or verbal agreements shall exist unless and until they are put into writing and signed by both parties. No unethical, illegal, or illicit agreements are authorized by this agreement. Should any activity, practice, or habit be discovered by either party that in any way violates law or ethics or otherwise casts a shadow upon this agreement, it is the obligation of either party to bring the matter up for immediate discussion and clarification.

Certification

I hereby certify that I have accurately and truthfully represented myself with regard to the requisite training, education, and legal (licensing) status in the attached curriculum vitae which I have signed and dated. I hereby agree to abide by the above provisions for employment.

_____ _____

Employee **Date**

_____ _____

Employer **Date**

Attach, sign, and date:

1. Curriculum vitae

2. References forms

3. Malpractice Face Sheet

Personal References for Employment as a Psychotherapy Trainee

You have my permission to contact the following people for references about my character, background, qualifications, and work. A photocopy of this page is an equally valid permission.

Reference: _____

_____

_____

Reference: _____

_____

_____

Reference: _____

_____

_____

_____ _____

Trainee Date

_____ _____

Print Full Name Birth Date

Section Four

Special Information and Forms Regarding:

HIPAA

Treating Children in High Conflict Divorce/Custody Situations

Caregivers Authorization for Medical Care Affidavit

Family Custody Evaluation Disclosure

General Information on HIPAA

Introduction: Changes in the federal law known as the *Health Insurance Portability and Accountability Act* (*HIPAA* — 45 CFR 160 *et seq*.) have begun to impact the ways in which health care information is obtained, stored, used and disclosed. HIPAA is being implemented in California via SB 456, which was passed and signed into law on October 8, 2001.

Due to *HIPAA's* "preemption clause," which bars *HIPAA* from preempting state laws that offer as much or more protection for patient privacy than *HIPAA* itself, the California Office Of HIPAA Implementation (CalOHI) was established under state law as of 1/1/03. Among the many duties of CalOHI is the clarification of which California state laws will be preempted, modified or left unchanged as a result of *HIPAA* compliance requirements.

Information about implementing HIPAA in California: Because of this lack of clarity, the reader is advised to stay informed about developments in California law through the following organizations and websites. Other states have similar information agencies. Contact your professional organization or attorney for how to obtain this information.

CalOHI: < www.ohi.ca.gov/state/calohi/ohiHome>

California Healthcare Foundation: < www.chcf.org/

How to get the correct forms: the following organizations/websites offer training and access to state-by-state forms for the implementation of *HIPAA* by professionals:

Psychologists: American Psychological Association's website for professionals:

www.APApractice.org

Licensed Clinical Social Workers: National Association of Social Workers website:

www.naswdc.org

Marriage & Family Therapists: California Association of Marriage & Family Therapists website:

www.camft.org

How *HIPAA* applies to the forms with this Updated Edition: The reader is advised to make sure to provide copies of the Notice of Privacy Policies (available for the professions at the society websites above) in conjunction with use of the following documents provided with this updated Edition:

1. Informed Consent for Psychotherapy Assessment Consultation

2. Informed Consent for Dynamic Psychotherapy or Psychotherapeutic Consultation (Individual, Couple, Group, and Family)

3. Informed Consent for Infant Relationship-Based Therapy

4. Informed Consent for Work with Children and Adolescents

5. Permission to photograph, audio tape and/or record

6. Psychotherapy Client Questionnaire

In addition, the reader is advised to provide the following information along with the Notice of Privacy Policies:

"Federal law requires me to provide you with the Notice of Privacy Policies for safeguarding your personal and protected health information. However, because the federal law is not as yet fully implemented in California, I will follow California state law where it is as protective or more protective of your privacy than *HIPAA*, and where *HIPAA* allows me to use California state law."

Progress Note/Clinical Record

Patient name:_____

Date of Service_____ Length of Session_____ Start_____ Stop _____

CPT: 90806/90818/90847/90853/Other_____ Diagnoses: _____

Symptoms: _____

Axis IV Psychosocial and Environmental problems addressed:

____Primary support group problems
____Social environment problems
____Physical health problems
____School/work problems
____Housing problems
____Self-care problems
____Economic stressors
____Current victimization
____Other psychosocial stressors

Current GAF: _____ Highest GAF this year _____.

Current Meds: _____.

Risk issues assessed_____.

Consultations: _____.

Tx Plan_____.

Informed consent issues discussed this session: _____

_____

_____

_____

(Signature)_____

Psychotherapy Note

Patient Name _____Date_____

Disclosures this session_____

_____

_____

_____

Interventions this session _____

_____

_____

_____

Patient Comments/Behaviors_____

_____

_____

_____

Homework_____

Signature_____

Release of Information for Outpatient Psychotherapy Records

I, _____
(Patient)

authorize _____
(Professional)

to release information as follows:

I. Specific information requested and its intended use: (to whom, for what)_____

_____

_____

II. Length of time the information will be kept before being destroyed or disposed of:

_____

(I understand that, in order to keep the information longer than the time specified, I must be notified of the extension and the specific reason for the extension, the intended use of the information during the extended time and the expected date of the destruction of the information.)

III. I understand that the information will not be used for any purpose other than its intended use.

IV. I understand that the person/entity requesting the information will destroy it and all copies of it in the person/entity's control, will cause it to be destroyed or will return it and all copies of it to me, before or immediately after the length of time specified in item II (above) has expired.

V. I have received a copy of this written request 30 days prior to sending the requested information, or I have signed a written waiver in the form of a letter submitted to the provider of healthcare ("Professional," above) waiving notification.

VI. The professional (above) is not authorized to disclose information to any other person/entity without my consent.

Name (printed): _____

Signature: _____

Date:_____

Treatment Summary

California Health & Safety Code 123130 holds that a treatment summary may be prepared in lieu of a patient record, within 10 working days of the request (if a record is unduly long or a patient is recently discharged, 30 days are allowed, but the patient must be notified in writing). Summaries must include:

(1) Chief complaint or complaints including pertinent history.

(2) Findings from consultations and referrals to other health care providers.

(3) Diagnosis, where determined.

(4) Treatment plan and regimen including medications prescribed.

(5) Progress of the treatment.

(6) Prognosis including significant continuing problems or conditions.

(7) Pertinent reports of diagnostic procedures and tests and all discharge summaries.

(8) Objective findings from the most recent physical examination, such as blood pressure, weight, and actual values from routine laboratory tests.

Fees:

The health care provider may charge no more than a reasonable fee based on actual time and cost for the preparation of the summary. The cost shall be based on a computation of the actual time spent preparing the summary for availability to the patient or the patient's representative. It is the intent of the Legislature that summaries of the records be made available at the lowest possible cost to the patient.

Account of Disclosures

[Mandated by HIPAA]

Client Name: _____

Date of Birth: _____

Disclosures to: (Name and address)	Purpose of Disclosure	Date

NOTICE: This is the Client Record

WARNING! All materials intended for exclusive use of therapist must be kept in a separate "Confidential Psychotherapy Notes" folder.

The contents of this Record are **ONLY** to include: face sheet information, informed consents, patient information, general diagnosis, functional status, treatment plan progress, billing and insurance information form, appointment information, length of session (starting and ending times), medication and referral information, and a termination summary.

A general release of information must be signed and dated by client before information from this folder can be released. With a signed release and/or subpoena the appropriate portions may be released. The client; (a) has a right to review this folder and to request a copy, (b) the client has a right to revoke consent. Further, **the client has a right to amend this record, (but legal consultation must be sought before amendment is included).**

All released information *must be logged* in this folder on special log sheet: to whom, for what purpose, what was sent, date released, signed and notarized (if there is any question of identity), client release or government subpoena. Client releases must accompany attorney's subpoena. Seek legal consultation regarding questions.

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This Folder Contains Psychotherapy Notes
WARNING! Criminal Penalties

Federal HIPPA Legislation caused this **CONFIDENTIAL PSYCHOTHERAPY** file to be created ***for the exclusive use of the treating therapist***.

1. Special federally regulated authorization forms signed by the client are required for the release of **any** part of this file.
2. Clients **do not** have the right to review or copy this file.
3. Legal consultation must be sought regarding authorization for release of any part of this file for subpoenas of **any kind**!
4. No part of this file that has been created by someone other than the treating therapist may **ever** be released without (a) documentation that the creator is dead or unavailable **AND** (b) legal consultation.
5. Any material released from this folder must be logged on the log sheet (to whom, for what purpose, what was sent, what date, signed and notarized if there is any question of identity release from client).

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2. Clients **do not** have the right to review or copy this file.
3. Legal consultation must be sought regarding authorization for release of any part of this file for subpoenas of **any kind**!
4. No part of this file that has been created by someone other than the treating therapist may **ever** be released without (a) documentation that the creator is dead or unavailable **AND** (b) legal consultation.
5. Any material released from this folder must be logged on the log sheet (to whom, for what purpose, what was sent, what date, signed and notarized if there is any question of identity release from client).

This Folder Contains Psychotherapy Notes
WARNING! Criminal Penalties

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NON-HIPPA COMPLIANT FILE

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WARNING! RELEASE OF PARTS OF THIS CONFIDENTIAL FOLDER WITHOUT PROPER AUTHORIZATION IS A FEDERAL CRIME AND MAY RESULT IN IMPRISONMENT OR UP TO $250,000 FINES TO THE PERSON RESPONSIBLE. LEGAL CONSULTATION MUST BE SOUGHT REGARDING ANY QUESTIONS OF RELEASE. Compliance with the Federal HIPPA Legislation was required in April 15, 2003. This folder was retired to inactive prior to that time and so **has not been reviewed to assure compliance.**

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Treating Children in High Conflict Divorce/Custody Situations: a sample agreement

I. To the Parent(s):

Thank you for entrusting me with the psychological care of your child. My role is to help your child develop the coping skills needed to handle the powerful forces at work in his/her life, both now and into the future. I understand that parents' worst fears are that their child will be either clinically mistreated or that I will somehow "side" with one parent at the expense of the other (and that I will not be receptive to the input of that other parent). These fears are a part of the forces at work in the child's life and the ways they are handled can "make or break" a child's treatment.

In order to increase the chances that my work with your child will be the best it can be, I have addressed some of these concerns in writing. I will be happy to discuss any of this material with you at any time, but it's very important that you acknowledge having read and understood this document before I begin to see your child.

California law requires that I try my best to work with both parents of children I see, whenever possible, so I make effort to contact both parents and to document any reasons for working only with one parent, along with the steps I am taking to involve the other parent. I normally require that both parents sign an authorization to treat their child, even if one does not have physical (or even legal) custody. The law also gives both parents reasonable expectations for information from me about their child's progress or lack of it. The law grants me the right to withhold information that I believe will result in damage to my professional relationship with the child or will place the child in physical or emotional danger, if disclosed.

Professional values suggest that even young children are entitled to expect that their communications to me will be confidential and the law suggests that they may actually be able to prevent information they share with me from disclosure in legal settings (that is, children have been able to "assert privilege" in certain situations). Courts seem to differ about this issue, with some considering a child's age/maturity level in making these decisions.

For these reasons, I ask parents to allow me to share only what I am required by law to share—circumstances when a child is behaving in ways that endanger himself/herself, others or property—and information that a child wishes discussed with parents. I ask that parents help me make therapy a "safe" place for children to learn coping skills by not applying pressure of one form or another to influence the treatment process or to move it in one direction or another. I do want parents to keep me informed of what they see happening in their child's life, but communications by parents do not carry guarantees of confidentiality. I can and do share parent communications with children, taking their ages and maturity levels into consideration.

I also want parents to understand that there are two requests that I cannot grant, as doing so would endanger the safety of the child's therapy: I do not confer with attorneys for either side in a divorce or custody dispute (nor do I hold lengthy conferences with one parent that I would not hold with the other parent); and I do not write letters or make statements about which custody or visitation arrangements I believe to be in the "best interests of the child." These types of discussions and comments are appropriate for formal forensic evaluators who are charged with the responsibility to thoroughly evaluate a child's family relationships and make recommendations to the courts. My job is to describe and treat children's symptoms with a goal of increasing their capacity to cope with the forces active in their lives. I may choose not to confer with a forensic evaluator appointed by the court to make recommendations about visitation/custody. I can and will confer with a child's own attorney, if one has been retained or appointed, or a child's legal guardian, if one has been appointed.)

However, there is no doubt but that parents do have the capacity, with enough legal pressure, to force me to disclose information (verbal and/or written) to the courts, even when I think it would be better for their children if they did not involve me in this way. I will try to be as clear with your child as possible as to the limits of confidentiality and to the issue of privilege as regards the things s/he might share with me. This clarity might result in your child being less open with me than if there were absolute confidentiality and privilege, but we live in a real world and understanding these issues is a part of the very coping skills I will try to teach to your child.

One final thought: in many cases where children are caught in high conflict divorce/custody situations, the conflict between the parents results in demands that treatment be discontinued with one clinician and that another one be sought to continue the child's care. Sometimes there are good reasons for changing clinicians—sometimes not. In any case, my general policy is that when either parent is dissatisfied enough to demand that I stop providing services to their child, I will actively consider transfer and will request that both parents allow for a transition that is smooth and professional and thus least damaging to the child.

I have read and understood this agreement:

Parent Name:_____

Parent Signature: _____

Date: _____

II. To the Child (and presented in language the child can understand):

Your parent(s) have asked me to help you learn to cope with the things that are happening in your life as they struggle with their relationships with you and with each other. I have asked them to do their best to allow us to keep our meetings private and safe—to ask no questions, to allow me to work with both of your parents, and to respect your needs for privacy.

I want you to understand that I know how hard it can be for kids to be going through the part of life you are facing. Parents have very strong fears about how their kids will be impacted by divorce and custody conflicts. Each is afraid that their child will misunderstand them, be wrongly informed about them or be guided away from them. These fears are among the strongest feelings that people can have and I have no doubts but that the power of these feelings is strong enough to make it hard for us to be sure that we have the safety and privacy for you to learn the coping skills I'd like to teach you.

You need to know that the general rule about counseling and therapy is that you can expect that I will do my best to keep the things you say to me private. Even in court, you can ask a judge to prevent me from talking or sharing records about things you want to keep between us. However, the judge won't always agree with you or with me. There are times when judges require counselors or therapists to speak or share records about things that children don't want to be known, and understanding this allows you to think about what you tell me and how you tell it to me.

You can expect that there are some things that I will definitely share with others — things that involve protecting you if you are doing things that pose a danger to yourself, others (and, if you destroy property, I won't be able keep that private if it gets

you into legal trouble). In these situations, the law is clear that your privacy isn't as important as your safety or the safety of others. I am also required to report reasonable suspicions of child abuse.

Finally, there may come a time when one of your parents becomes distressed enough or concerned enough about your counseling or therapy with me that they insist that we stop working together. Except under the most unusual circumstances, if things get that serious, we will have to consider looking for a different counselor or therapist for you, even if we both feel strongly that we work well together. It isn't so much that I would be too upset about being criticized by whichever parent wanted us to stop seeing each other—it's that parents' feelings about these things are so strong that we would probably wind up talking about your parent more than we would about you—and you are the one who really counts when it comes to your own counseling or therapy sessions.

If you have an attorney that represents you—or a court-appointed guardian - I will be glad to speak with him/her and will discuss anything that I might say with you first. I will try my best not to speak with attorneys who represent either of your parents and I will let you know when either your parents or one of their attorneys contacts me so we can decide what to do.

I am so sorry that things are difficult and I want you to know that I will work very hard to make our work together as productive and safe for you as I can.

Patient Name: _____

Patient Signature: _____Date:_____

Caregiver's Authorization Affidavit

Use of this affidavit is authorized by Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code.

Instructions: Completion of items 1-4 and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. Completion of items 5-8 is additionally required to authorize any other medical care. Print clearly.

The minor named below lives in my home and I am 18 years of age or older.

1. Name of minor: _____.

2. Minor's birth date: _____.

3. My name (adult giving authorization): _____.

4. My home address: _____

_____.

5. ( ) I am a grandparent, aunt, uncle, or other qualified relative of the minor (see back of this form for a definition of "qualified relative").

6. Check one or both (for example, if one parent was advised and the other cannot be located):
( ) I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care, and have received no objection.
( ) I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time, to notify them of my intended authorization.

7. My date of birth: _____.

8. My California's driver's license or identification card number: _____.

Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: _____ Signed: _____

Family Custody Evaluation Disclosure

Purpose

The purpose of a custody evaluation/visitation evaluation is to assess the individual and family factors that affect the best interests of the children. A primary goal is to provide the attorneys, and the Court, with objective information and recommendations for the custody of, parenting of, and access to children in those cases in which parents are unable to work out their own parenting plans. Hopefully, these recommendations will serve as a basis for settlement negotiations between the parents and/or attorneys.

Procedures

1) Interviews: Interviews will be conducted with each parent alone, or with their current spouse or significant other, and jointly with the other parent if applicable. The children will be evaluated with each parent if applicable, and alone and/or jointly. New spouses or significant others will also be interviewed. Interviews typically take place in the evaluator's offices, but may include a home visit.
2) Information from Collateral Resources: You will be asked to identify collateral resources who might have useful insights about the family. These are individuals who know you, or the other parents, or the children. Preference should be given to those who have had near equal contact with both parents. Provide the individual's name (e.g., Mr. Tom and Mrs. Helen Johnson, not just Mr. Tom Johnson, when you wish them to be separate collateral contacts). Examples of collateral resources include: day care providers, teachers, activity leaders, mental health professionals, pastors, health care providers, law enforcement agents, etc. Releases will be

signed prior to contact with these individuals. Neighbors, housekeepers, relatives and friends may also have impressions and opinions, and may be contacted. However, professional resources are usually more objective in their assessments.

3) Psychological Testing: Parents, new spouses or significant others, and the children may complete relevant psychological testing.
4) Review of Written Information & Records: The parents unless otherwise advised by counsel, agree to furnish all documents that are requested by the evaluator, including, but not limited to: declarations pertaining to custody, parenting, and the children's needs, Court Orders, and other documents, medical evaluations, all previous psychological evaluations, school records, letters, diaries, logs, and police reports. Parents and/or their attorneys may want to present a written statement of issues, concerns and wishes at the start of the evaluation.
5) Final Report: At the end of most evaluations a written report is completed. It includes discussion of the findings and recommendations regarding the best interests of the children: custody and visitation plans.

The written report will be released to the attorneys of record, and to the Court, not to the parent. In the case of pro per clients, the report will be released to the Court.

Limits of Confidentiality

There is no privileged communication for any party in custody evaluations. All information obtained during the evaluation may be reported to the Court and the attorneys in the case. Release of information is not required for the Court-ordered evaluator to speak to collateral contacts. If you or your child is, or has been, in therapy, you may have your own psychotherapist-patient privilege. Releasing confidential

psychotherapist-patient records to me, may result in those records also being available to the Court and/or the child's other parent.

All relevant contacts between the evaluator and every party to the litigation will be noted and reported.

The evaluator will not review illegally obtained information.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together.

This signed Authorization signifies that (evaluator) has provided information to me in the following manner:

1) Has reviewed the purpose of the psychological evaluation and mental examination to be conducted as he understands it.
2) Has explained the nature of the procedures to be employed.
3) Has explained the intended use of the evaluation as he understands it.
4) Has revealed the identity of the party/parties that retained him.
5) Has explained the limitations on confidentiality of the psychological evaluation and mental examination and records generated.
6) Has explained that there is no psychotherapist/patient relationship being created, and that the role of the evaluator may continue beyond the release of the report/or Court date.
7) Has explained that the psychologist/patient privilege does not exist.

8) Has explained that the information and records generated may be released, for child custody, to the attorneys and the Court.

By signing below, I am affirming that I fully understand, consent and agree to the above terms and conditions and I give my consent for (evaluator) to conduct the psychological evaluation and mental examination of me.

Financial Agreement

Professional time for forensic evaluations and child custody evaluations is billed at _____ per clock hour. The total professional time involved in a forensic evaluation includes face-to-face contact with the adults, adolescents, or children within the family. This may also include time spent with the significant other family member and friends. In addition to the actual evaluation with family members, the professional time also includes review of documents and records, contact with other significant professionals (e.g., teachers, therapists, police, and other community agencies), and telephone contacts. In addition, scoring and interpretation of testing, and report writing, are all billable time. Any work done by the professional, or the professional's office, after completion of the report, whether requested by the client or the client's attorney, will be billed to the client at the professionals current rate.

Special services (e.g., home visits) will be billed per hour or partial hour (portal-to-portal).

1) I agree that I am accepting treatment, evaluation, consultation, **outlining,** report or letter writing for myself or another member of my family provided by (evaluator) or another therapist and I understand that I am responsible for the charges and agree to pay for services rendered in accordance with the stipulated

or Court-ordered assignment of responsibility. Should my attorney, acting on my behalf, ask for a letter or report, I am responsible for this charge.

2) I also understand that **phone conversations,** interviews, and **reading** of information in my case longer than ten minutes will be charged accordingly. If I or my attorney requests the evaluator to read information about my case, I will be charged for the time involved in reading according to the stipulated or Court-ordered assignment of responsibility.
3) Failure to pay for services can result in court or collection action being taken against me, and if this does arise, I understand that I will be responsible for attorney, court and collection costs.
4) I will be responsible for paying .0083% per month billing charge on the unpaid balance owed thirty days or more.
5) If a check is returned from the bank for insufficient funds, or if I stop payment on a check, or close the account, then that amount becomes due and payable, with a .0083% per month billing charge beginning on that date, with an additional $20.00 charge per check. Checks will be held for 14 days, and then will be turned over to the police for criminal prosecution. I may be liable for triple damages if my check is returned and I do not deliver cash or certified funds within 30 days, according to California Civil Code, Section 1719.
6) **I will give 24 hours notice if cancellation (not counting weekends), or I will be charged for the time allotted.** I understand there is an answering or message service available around the clock to leave messages.

7) In signing this agreement, I accept that I am jointly and severally liable, with any co-signer of this Agreement for all charges incurred under the terms of this Agreement.

Financial Agreement for Court Time and Deposition

The following is understood in advance of the court date:

a) If I or my attorney asks that (evaluator) or any of his associates be available to testify in court, either by verbal agreement, letter or subpoena, then I am responsible to pay in advance of the court date, the hourly fee of $_____ for each hour of court testifying time or waiting-to-testify time, plus the time it takes to travel to and from the courthouse, plus the time for preparation for court. Deposition, deposition preparation, deposition review and transportation associated charges are billed at the rate of $_____ per hour. I am aware that I am paying for time reserved for me and time away from (evaluator) or his associate's practice, and not for actual time of testifying.

b) If the court case or deposition is continued and (evaluator) or his associate is asked to be available to testify for the new date, then I am responsible to pay for this new date as well as the previous date or dates, in accordance with the agreement in paragraph letter (a).

c) If I or my attorney provides 48-hours notice (not counting weekend time) of cancellation of (evaluator) or his associate's appearance, then I will not be charged for that date.

d) The minimum time that will be allotted is the afternoon (1:30 to 5:00 p.m.). If morning time is requested, then I understand that the whole day will need to be reserved for testimony.

e) This document requires signatures of both parties, if married or living together.

f) I have read the above and fully understand and accept the procedures related to court or for giving a deposition, and all other terms of the contract.

Preparation of Court Reports

Total time needed to write the Court report depends on numerous factors. This includes: the review of all Court records; the reading of all materials given to the evaluator to review, which may include school records, collateral reference inquiries and professional references inquiries, as well as the Psychosocial Parenting Inquiry.

An estimate will be given at the initial contact. These are merely estimates, and the time is often longer if the case is highly complicated; if there are numerous people to be evaluated; and if the case requires extensive review.

Retainer

We require 75% of the estimated cost as a retainer when the evaluation begins, and the balance is to be paid before the Court report is written and released to the attorneys and the Court. If two parties are splitting the costs, both parties must have paid their bills in full before any report will be written and released. Any disputes about who pays for the services needs to be resolved before services are rendered.

Please be aware that when you pay your retainer, you will owe at least ¼ of the same amount before the report is written and released to the attorneys and the Court. We urge you to make payments on your account each time you are seen in the office. The

retainer only gets the evaluation underway. Frequent payments will assist in the timely release of your report.

Final Payment

All final payments must be paid in cash or by a cashier's check. **NO EXCEPTIONS!** Payment plans are not an option.

Insurance Reimbursement

We will be glad to complete insurance forms to obtain reimbursement for services provided where applicable, but only after the full Court report has been paid for by all parties. You should be aware that from our experience, most insurance companies will not pay for a 730 evaluation since it is not psychotherapy, but a Court evaluation for a legal purpose. Only those fees that are the result of clinical services and established medical need can be legitimately billed to the insurance company. As there is no patient or psychotherapeutic relationship, this reduces the likelihood that insurance will pay for services rendered.

We cannot bill for time involved in services that are legally related (i.e., review of legal documents, writing a report for legal purposes, testimony or deposition). If there is no diagnosable psychological condition requiring psychological assistance, insurance companies generally will not pay for any of the costs.

The undersigned accepts the terms herein outlined, certifies that he/she has read the foregoing, and has received a copy of this financial agreement, and is the client or is authorized to sign as the client's agent. By signing, you understand the financial obligations for this 730 Court ordered evaluation.

Confidentiality

There are some situations when information may be shared. These are:

1) Potential danger (to self/others/property);
2) Child abuse and/or adult abuse;
3) Mental status in litigation and administrative procedures;
4) Breach of contract (small claims court);
5) Court-Ordered evaluation.

Evaluations

Although I am hired by you, my opinion is my own. My opinion is completely independent of any monetary compensation. I do not guarantee any result or outcome. The Court may utilize my recommendations or completely disregard them.

Following the guidelines for forensic psychology, I will not make a recommendation regarding child custody if I have not had the opportunity to interview both parents in a dissolution.

The Court finds, pursuant to the stipulation of the parties, separate and apart from the other terms of this Order, that in performing the evaluation, the expert will be engaged in a quasi-judicial (including, but not limited to, referee and/or arbitral function) and shall be entitled to quasi-judicial immunity and statutory immunity.

Counsels are directed to contact (evaluator's name and contact information) to arrange for payment of the Minimum Estimated Fee Deposit. A $775.00 non-refundable Administration Fee is charged after the parties stipulate to (evaluator's) appointment. All out-of-pocket expenses for services, messenger services, etc., will be charged back to the client(s).

The fixed non-refundable Administrative Fee of $775.00 shall be charged against any monies received regardless of when the process terminates. The Administration Fee can be deducted from any monies received regardless of source.

Notwithstanding any other provision, in the event any person (including children) fails to appear at the time of the scheduled appointment, or fails to give 24-hours notice to cancel, the party responsible for the cancellation shall be obligated to pay the fees for each missed appointment, unless other arrangements are made.

Each party is ordered to cooperate with the expert in briefly deviating from any existing custody-visitation schedule, if necessary, to permit a child or children to spend periods of time in the care of each parent prior to an evaluation session in the company of that parent. This provision authorizes the evaluator to make short term scheduling revisions for evaluation purposes, but not to impose trial plans, etc.

When deemed advisable by the evaluator, the parties and/or child(ren) shall submit to drug/alcohol tests, to be conducted by experts designated by the evaluator. The costs of such tests are paid by the party or parties ordered to pay the fees for the psychiatric/psychological evaluation, and shall be paid directly to the laboratory.

Each party hereby waives all statutory and non-statutory privileges, including his or her respective doctor-patient and psychotherapist-patient privilege so as to permit the evaluator to have access to health, mental health, education, employment and other similar records, to confer with healthcare providers, therapists, educators, and other persons whom the evaluator deems necessary for the purpose of performing the evaluation, and for them to confer with the evaluator. Each party shall execute

authorizations for release of information to provide the evaluator access to such records of persons. You are advised to contact your attorney prior to agreeing to this provision.

All written communication and documents, including any enclosures to said written communications, shall be provided to (the evaluator) and to both counsel.

The evaluator has the right to determine, in his professional opinion, the information that he deems significant and relevant to the custody matter.

The evaluator is permitted to consult with or exchange information with professionals and other collateral informants he deems appropriate in conducting this evaluation and preparing this report.

Neither counsel nor parties shall engage in unilateral communication (e.g., by mail or telephone) with the evaluator unless in response to request. If either party furnishes any material to the evaluator, they shall first submit to their attorney who will copy it to opposing counsel.

Information contained in the evaluator's file may be released in a Family Law matter only by Court Order and not by subpoena. There shall be a fee for file retrieval and duplicating expenses, which must be paid in the form of a CASHIER'S CHECK or MONEY ORDER. The fees shall be mailed or delivered to (evaluator) with at least fifteen (15) Court days notice. Some materials may not be reproducible due to copyright laws. Attorneys and parties are not permitted access to psychological test data, unless Court-ordered.

The evaluator or his associates shall not be called upon to testify in any other matter related or unrelated to the above-captioned case or as a percipient witness.

For the purposes of protecting the parties' child(ren), counsel may show to and/or review the contents of the report with the parties, but may not provide the parties with a photocopy or the original thereof for purposes of photocopying or otherwise retaining in their personal possession.

I have read the materials presented in this disclosure statement. My signature indicates that I understand the information, agree with the conditions of therapy or evaluation that are either stated or implied here, and I commit myself to compliance with them.

_____

Dated Signature/Client

_____

Dated: Signature/Client

_____

Dated Evaluator