Limits of Patient Confidentiality

I, Ruth Lynch, LMFT, greatly respect your right of privacy, especially regarding information you share in psychotherapy. I also believe you should fully understand the limitations of confidentiality in order for you to make an informed decision regarding what you disclose in therapy. Some of the limits of patient confidentiality are listed below and I may be required to disclose confidential information if any of the following conditions exist:

Initial: _____ You are a danger to yourself or others.

Initial: _____ You waive your rights to privileges or give consent to limited disclosure by your therapist

Initial: _____ You file suit against your therapist for breach of a duty or if your therapist files suit against you.

Consent to Treatment

Initial: _____ I understand the importance of not being under the influence of any mood altering drugs before or during my scheduled session. It is highly suggested that no substances are used within a 24 hour period following the session.

Initial: _____ I understand that I need to be in a place of privacy, just like I would be in an in-person therapy office setting for my scheduled session.

Initial: _____ I do hereby seek and consent to take part in the treatment by the therapist named above. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest.

Initial: _____ I understand that no promises have been made to me as the results of treatment or any procedures provided by this therapist and that the treatment may not work, changes may be disruptive, and the process may be emotionally unsettling.

Initial: _____ I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. *For example, if my treatment has been court-ordered, I will have to answer to the court.*

Initial: _____ As an alternative to therapy there are available recovery and support groups, self help programs, and books.

Initial: _____ I know that I must contact Ruth Lynch,LMFT to cancel an appointment at least 24 hours before the time of the appointment. I understand there may be cases of illness but I need to call in a timely manner. A late cancellation/no show fee of $150 will be charged for the missed session time.

Financial Agreement

Initial: _____ I understand that scheduled appointments are reserved for me. I will notify the therapist as soon as possible if I am unable to attend my session. I will be charged a cancellation/no show appointment fee(for under 24 hours prior) of $150 for the missed session time.

I hereby assume full responsibility for any charges incurred that are not reimbursed by my insurance provider or any other charges that may be incurred regarding my treatment. I understand that payment of said charges is not contingent upon any insurance coverage I might have or obtain.

Signature: _____ Print Name: _____ Date:_____

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