Privacy and Rights Acknowledgement

Patient Name:_____ Date:_____

Please read the following polices and initial below:

Initial_____ I have read and understand my **Patient Rights**, stating as a patient of Hope for a Better Tomorrow, I have specific rights that are enumerated in Wisconsin Statutes 51.61 and Wisconsin Administrative Code HHS 94.

Initial_____ I have read and understand the **Cancellation Policy** stating that I can be charged a $50.00 cancellation fee if I cancel my appointment with less than a 24 hour notice. (Unless due to illness or emergency)

Initial_____ I have read and understand my **Limits of Liability Policy** stating therapy services carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of my life are considered risks of therapy sessions.

Initial_____ I have read and understand my **Limits of Confidentiality** stating what I discuss during my therapy session are kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of my legal guardian. The following is a list of exceptions: Duty to Warn and Protect, Abuse of Children and Vulnerable Adults, Prenatal Exposure to Controlled Substances, Minors/Guardianship and Insurance Providers and Hope for a Better Tomorrow Clinician Collaboration

Initial_____ I have read and understand the **HIPAA** stating how therapeutic and medical information about you may be used and disclosed, your rights as a patient and ways for you to get additional information on our policies. Our clinic has always been very protective of your personal information. Under new federal regulations (HIPAA Privacy Act), we have adopted additional guidelines to ensure proper use, confidentiality, and disclosure of your health information.

By signing below, I am acknowledging that I have read and understand the above polices. Paper or electronic copies can be obtained per request.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Administrative use only

By signing below, I, administration, have gone through the above statements with the client or the guardian of the client, in person and offered them a copy of these polices.

_____ _____

Administrative Signature Date

Payment Acknowledgement Agreement

Patient Name: _____ Date:_____

Please read the following statements and initial below:

Initial ____ I understand and agree that my co-payment, co-insurance and deductibles are due and payable at the time of service. I understand that charges not covered by my insurance company as well as applicable co-payments and deductibles are my responsibility and will be subject to the therapists self-pay amount of $_____. I understand that co-payment and deductible amounts may change depending on my mental health benefits within my insurance policy.

Initial ____ I understand that any unpaid services will be considered delinquent and will be sent to a collection agency.

Initial ____ I understand and agree that I will be charged a $50.00 cancellation fee if I cancel my appointment with less than a **24 hour notice**. (Unless due to illness or emergency)

Initial ____ I understand and agree to the $3 fee when using a credit or debit card other than medical cards to pay for any and all services. Cash and check are no charge. There will be a $20+ fee for any bounced checks.

By signing below, I understand and agree to the above statements. *I authorize my insurance benefits to be paid directly to Hope for a Better Tomorrow.*

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Administrative use only

By signing below, I, administration, have gone through the above statements with the client or the guardian of the client, in person.

_____ _____

Administrative Signature Date

HOPE FOR A BETTER TOMORROW

TREATMENT PLAN ACKNOWLEDGEMENT FORM

At Hope for a Better Tomorrow, you will participate in the development of your treatment plan. The treatment plan is your "map of care" which includes specific goals that you wish to accomplish. With your therapist, you will discuss frequency of treatment and what types of services and modalities will help you reach your goals.

Therapists at Hope for a Better Tomorrow strive to deliver the best possible care for their clients. In order to uphold this high standard, we ask for your signature to acknowledge that you have played an active role in the treatment planning process.

If you have further questions regarding this form, please consult with your therapist.

Client Print Name:_____ Date:_____

Client Signature: _____ Date:_____
(Parent or Guardian if under 18)

Health Risk Assessment – Child
*Age 0 to 17 years old

Name: _____ Date: _____

Please circle the number which best identifies your response to each corresponding question-
N/A Never 1. Almost Never; 2. Occasionally;
3. Often; 4. Very Often; or 5. Always or Almost Always

1. My child engages in moderate physical activity for at least 20 to 30 minutes at least 5 days of the week.

   N/A 1 2 3 4 5

2. My child enjoys physical activities rather than sedentary activities.

   N/A 1 2 3 4 5

3. My child eats at least five servings of fruits and vegetables every day (one serving equals one half cup).

   N/A 1 2 3 4 5

4. My child eats at fast food restaurants more than three times per week.

   N/A 1 2 3 4 5

5. My child sees a physician for routine check-ups, health screenings, and disease prevention.

   N/A 1 2 3 4 5

6. My child is in a car or booster seat when traveling in a vehicle.

   N/A 1 2 3 4 5

7. My child and I take time to have meaningful interactions with one another.

   N/A 1 2 3 4 5

8. My child is able to develop close, personal relationships with others.

   N/A 1 2 3 4 5

9. My child demonstrates self-confidence and/or a positive self-esteem.

   N/A 1 2 3 4 5

10. My child expresses his or her feelings of anger and frustration in ways that are not hurtful to themselves or others.

    N/A 1 2 3 4 5

11. My child feels comfortable confiding in family or friends to assist in managing stress.

    N/A 1 2 3 4 5

12. My child seeks opportunities to learn new things through different mediums such as television, books, newspaper, internet, etc.

    N/A 1 2 3 4 5

13. Before making decisions, my child gathers facts and considers all viable options.

    N/A 1 2 3 4 5

14. My child has a healthy balance between school work and leisure time.

    N/A 1 2 3 4 5

15. The level of stress in my child's life is manageable for him/her.

    N/A 1 2 3 4 5

16. My child has hopes and dreams for his or her future.

    N/A 1 2 3 4 5

17. My child's actions are guided by the family's own beliefs rather than the beliefs of others.

    N/A 1 2 3 4 5

HOPE FOR A BETTER TOMORROW

INFORMED CONSENT POLICY

It is the policy of this clinic that each patient, or individual acting on behalf of the patient, will receive specific, complete and accurate information regarding the psychotherapy or other treatment they receive at all of our clinic locations. It is our agency's policy to offer this information in both verbal and written form. All patients will be provided, and should take, the necessary time to review this informed consent policy prior to the onset of treatment. You may also ask for additional information from your therapist regarding any particular treatment at any time during the course of treatment.

Completed and accurate information must be provided concerning each of the following areas:

1. The benefits of the proposed treatment.
2. The way in which the treatment will be administered, the treatment schedule, and my involvement in the development of my treatment plan.
3. The expected side effects from the treatment and/or risks of side effects from medications.
4. Alternative treatment modalities.
5. The probability of consequences of not receiving treatment.
6. The consequences of the continued use of alcohol or other drugs, unauthorized absences or any other evidence of noncompliance.
7. My financial obligations regarding my treatment cost.
8. Information regarding sexually transmitted diseases and communicable diseases.
9. The time period for which the informed consent is effective.
10. Your rights as a patient to withdraw the informed consent at any time in writing.
11. Hope for a Better Tomorrow provides mental health services at our facility. Mental health staff may be involved in your treatment planning and referrals may be made.
12. Client records are kept securely for mental health patients.
13. I understand that this informed consent is good for the course of treatment
14. I understand that this informed consent is to expire in 15 months.
15. I understand that I can withdraw my consent, in writing, at any time.

My signature indicates that (1) I have read and I understand the above policy and procedures pertaining to my granting of informed consent for the treatment which I choose to receive and (2) that I have been presented with the necessary and appropriate information either verbally or in writing, and that I have also had adequate time to consider this information, and that I do herby give my informed consent to participate in the recommended treatment. I have also received a copy of this document.

_____ _____

NAME (PRINT) DATE

_____ _____

SIGNATURE DATE

_____ _____

SIGNATURE (PARENT OR GUARDIAN) DATE

HOPE FOR A BETTER TOMORROW

PRIMARY PHYSICIAN & PSYCHIATRIST-PATIENT CARE COMMUNICATION FORM

Clinicians at Hope for a Better Tomorrow strive to deliver the best possible care for their clients. In order to uphold this high standard, we ask for permission to notify your primary care physician and/or psychiatrist. By signing this form, it gives your Hope for a Better Tomorrow therapist permission to contact your primary care physician and/or psychiatrist to introduce themselves as your behavioral health care practitioner and work directly with them when necessary (for example: strategies for better medication management, coordination of care and treatment recommendations).

If you have further questions regarding this form, please consult with your therapist.

Physician or Psychiatrist Name:_____

Address:_____

Phone:_____ **Fax:**_____

____ Yes, I want this information released to my Primary Care Physician or Psychiatrist.
____ No, I do not want this information released to my Primary Care Physician or Psychiatrist.
____ I do not have a Primary Care Physician or Psychiatrist at this time.

Authorization to Disclose Information

To the patient: Disclosure of the above information is for coordination of care between your physician and your behavioral health provider(s). The information released on this form is part of your protected health information and is protected under federal law. Releasing this information to your physician is strictly voluntary and does require your written consent for this form to be sent, it does not allow for any other information to be disclosed nor does it allow for any form of communication to take place. If you want your physician to receive additional information from your confidential records, a release of information for that purpose can be provided to you. To the party receiving the information: This information has been disclosed to you from records whose confidentially is protected by federal law. Federal regulations prohibit you from making further disclosure of this information.

This authorization can be terminated at any time in writing.
This authorization is valid for the duration of involvement, up to one year.

Print Patient Name: _____

Signed:_____ _____ _____
(Client 12 years of age and older) Date Witness

Signed:_____ _____ _____
(Parent or Guardian Signature, 12 years and younger) Date Witness

OFFICE USE ONLY
Letter and Form Sent: _____
Date & Initials

Acknowledgement and Consent to Use Electronic Communication

What is Electronic Communication? Electronic communication is any form of email, text messaging, and digital communication of any form to and from an individual utilizing a telephone, cellphone, computer, tablet, digital camera or any other form of digital technology.

Confidentiality and Electronic Communication
Hope for a Better Tomorrow (HFABT) understands that you may choose to use electronic communication, such as text messaging, to communicate with your therapist. This consent has been created to outline the potential benefits and risks to confidentiality when communicating with a therapist via. E-mail, text message, or any form of digital communication.

Confidentiality: The United States legislation passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to provide data privacy and security provisions for safeguarding medical information. In utilizing electronic communication, one's privacy and security may be at risk. HFBT is ethically and legally obligated to maintain records of all correspondence whether in person, by phone, or via electronic communication such as email or text messaging. HFABT will use reasonable means to protect the security and confidentiality of email and text information sent and received. However, because of the risks outlined below, HFABT cannot guarantee the security of email and text communication, and is not liable for improper disclosure of confidential information that is not caused by HFABT intentional misuse.

Limits to Confidentiality: Any matters of safety, such as reports of abuse, neglect, or "duty to warn" situations, are not covered under the laws of confidentiality outlined above. HFABT therapists are legally required to make reports to the Child Protective Services (CPS) or local law enforcement in the event such disclosures are made, whether in person or through electronic communication.

Potential Risks and Limitations of Electronic Communication

A. Risks and Limitations: Electronic Communication has a number of risks that clients should consider before using e-mail or text messaging to communicate with your therapist. The following is a list of the potential risks and limitations to using electronic communication.
    a. At HFABT, we have secure encrypted e-mails and systems. However, outside entities apart from HFABT may not.
    b. The use of electronic communication **does not** provide crisis intervention, therapy sessions or any form of clinical assistance to the client.
    c. No technology is 100% secure and HFABT cannot guarantee protection from unauthorized attempts to access, use, or disclose personal information exchanged electronically.
    d. Third-party services that feature text messaging or other direct electronic messaging may provide limited security and protection of confidential information.
    e. HFABT is ethically and legally obligated to maintain records of all correspondence whether in person, by phone or via electronic communication such as email or text messaging.
    f. Information regarding treatment or other personal information should not be communicated through text messaging or email.

B. **Emergencies:** I have been advised and understand any form of electronic communication is to be used for simplifying and expediting scheduling/administrative matters only.
    a. <u>Email & texting should NOT be used to communicate:</u>
        i. Suicidal or homicidal; thoughts or plans
        ii. Urgent or emergency issues (psychiatric or medical)
        iii. Serious or severe concerns or matters of safety
        iv. Rapidly worsening symptoms
        v. Changes to treatment plan
    b. <u>In a crisis or life threatening emergency clients should:</u>
        i. Call 911, go to your nearest emergency room or contact the following 24/7 hotline
            1. National Suicide Hotline : 1-800-273-8255
            2. Suicide and Crisis Lifeline: Dial 988
            3. Crisis Text Line: Text HOME to 741741

C. **Electronic Communication Agreement** – The types of information that can be communicated via email/text with your clinician during business hours includes:
    a. Appointment Confirmation
    b. Late arrival to regularly scheduled appointment
    c. Appointment Cancellation/Rescheduling

Consent

A. By signing this consent, I agree and understand the following:

a. I agree to the use of email/cell phone texting as needed and understand that electronic communication should only be used for scheduling and administrative purposes, within the guidelines above.
b. If more urgent assistance is needed, I will utilize the crisis services listed under "In a life-threatening emergency."
c. By signing, I, the client (parent/guardian) is not permitted to disclose or post digital or other electronic communications from social workers or other recipients of services without proper consent.
d. I understand that the use of email, cell phone or other forms of technology does not eliminate the option to provide verbal and/or face-to-face communication when checking in briefly with their therapist, changing appointments, last minute updates, or cancellations.
e. I understand that electronic communication is not to be used in place of therapeutic services, and clinical services can only be provided during scheduled in-person sessions.
f. If at any time my therapist or I believe email/texting is interfering in my therapeutic process, being used ineffectively, or in the event of inappropriate conduct (such as threats made towards staff), either party can revoke this consent. Termination of consent must be completed in writing and include the date consent is being terminated as well as signatures of both parties.

Please initial one of the two following choices:

_____I have opted not to provide consent for electronic communication. I will schedule appointments via phone contact or in person during scheduled sessions.

_____I have chosen to use electronic communication to coordinate scheduling with my therapist and administrative staff. I have read and fully understand the information provided to me. I have had the opportunity to discuss my questions and concerns with my therapist and/or HFABT administrative staff. I have provided my preferred form of electronic communication in my initial intake packet. I understand that standard messaging rates may apply, and that I am responsible for all fees related to use of electronic communication.

Client Name: _____

Client's Signature _____ Date: _____

If client is under 18 years old-

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

Adapted by Hope for a Better Tomorrow

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us and Hope for a Better Tomorrow.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, Hope for a Better Tomorrow may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if our Clinic Director believes it is necessary, we may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in-person, you agree to take certain precautions which will help keep everyone (you, me, and our families, Hope for a Better Tomorrow Staff and other clients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. *Initial each to indicate that you understand and agree to these actions:*

1. You will only keep your in-person appointment if you are symptom free. _____
2. You will wash your hands or use alcohol-based hand sanitizer when you enter the building. _____
3. You will adhere to the safe distancing precautions we have set up in the waiting room and therapy room. _____
4. If you choose, you may wear a mask in the office. Your therapist will wear a mask if specifically requested by you. _____
5. You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me, other clients and Hope staff. _____

Hope for a Better Tomorrow and its Clinic Director may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

Hope for a Better Tomorrow has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts in the office waiting room. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that Hope for a Better Tomorrow is committed to keeping you, me, the Hope staff and all of our families safe from the spread of this virus. If you believe that you have a fever or other symptoms, or believe you have been exposed, we will have to require you to reschedule your appointment for a later date or switch to a telehealth option, video or telephone. Cancellation fee will be waived if you need to cancel or reschedule due to symptoms being present or if suspected symptoms are present.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together. Your signature below shows that you agree to these terms and conditions.

_____ _____

Client Signature Date

_____ _____

Client Printed Name Therapist Name

Informed Consent for Telemental Health Treatment

Definition of Telemental Health

Telemental health services involve the use of electronic communications (telephone, written, text, email, video conference, etc.) to enable counselors to provide services to individuals who may otherwise not have adequate access to care. Telemental health may be used for services such as individual, couples, or family therapy. Telemental health is a relatively recent approach to delivering care and there are some limitations compared with seeing a counselor in person. These limitations can be addressed and may be minor depending on the needs of the client and the care with which the technology (cell phone, computer, etc.) is utilized. It is important that both the client and the counselor be in a place where there is the most privacy as possible during their sessions, and that the security of their technology be as up to date as possible with appropriate security protection.

Additional Points for Client Understanding:

1. I understand that telemental health services are completely voluntary and that I can choose not to do it or not to answer questions at any time.
2. I understand that none of the telemental health sessions will be recorded or photographed without my written permission.
3. I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.
4. I understand that telemental health may be performed over a communication that is not encrypted (e.g. Skype, Facetime). My counselor and I will work together to choose the telemental health communication system/program that will work best for my needs. I do accept the risk that this could affect confidentiality.
5. My counselor has explained to me how video conferencing technology and telephone procedures will be used. I understand that any telemental Health sessions will not be exactly the same as an in-person session due to the fact that I will not be in the same room as my counselor.
6. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that I or my counselor may discontinue the telemental sessions at any time if it is felt that the videoconferencing, text, email, or telephone connections are not adequate for the situation.
7. I understand that I may experience benefits from the use of telemental health in my care, but that no results can be guaranteed or assured.
8. I understand that if there is an emergency during a telemental health session, as with an in-person session, my counselor will call emergency services and my emergency contacts if needed clinically necessary.
9. I understand that in advance of the telemental health session a plan will be in place about how to re-connect if the connection drops while I am in a session.
10. I understand that my counselor and I will create and have in place a safety plan in case of an emergency (see below).
11. I understand I have the right to withhold or withdraw this consent at any time.

12. I understand the laws that protect the confidentiality of my personal health information also apply to telemental health, as do the limitations to that confidentiality discussed in the Information, Authorization, and Consent to Treatment document. I also understand that the dissemination of any personally identifiable images or information from the telemental health interaction will not be shared without my written consent.

Payment for Telehealth Services

Hope for a Better Tomorrow will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay the self-pay rate associated with their specific counselor.

Client Consent to the Use of Telehealth

I consent to engaging in telemental health as part of my treatment with Hope for a Better Tomorrow. I understand that "telemental health" includes the practice of health care delivery, diagnosis, transfer of personal health information via conversation, and psychoeducation using interactive audio, video, or data communications.

I understand the information provided above regarding telemental health. I have discussed the consent with my counselor and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemental health in my care.

_____

Print Name

_____ _____

Client's Signature Date

_____ _____

Parent or Guardian Signature Date

TELEMENTAL HEALTH SAFETY PLAN ADDENDUM

Client Name (first and last): _____

Physical Address of Client during telemental health sessions (primary address):

Street: _____

City: _____ County: _____ State: _____ Zip: _____

*(It is preferred that the client be asked their location at each session when using telemental health)

Client's Phone Number: _____

Emergency Contact (1): _____

Relationship: _____

Phone Number: _____

Emergency Contact (2): _____

Relationship: _____

Phone Number: _____

- I have provided two emergency contact numbers.
- If there is an emergency during a session, my counselor has permission to contact my emergency contacts.

Signatures:

_____

Client Date

_____

Counselor Date

INITIAL PSYCHOTHERAPY INTAKE
Child (0-13 years old)

Please provide the following information and answer all questions below. Please note: information provided here is protected as confidential information.

Part One:

Child's Name: _____
Last First MI

Birthdate:_____/_____/_____ Age:_____ Sex/Gender: _____

Does your child have a Preferred Name:_____ Does your child have a Preferred Pronoun? _____

Address: _____
Street Address City State Zip

Parent/Guardian #1: _____
Last First MI

Parent/Guardian #2: _____
Last First MI

Phone Number: (_____)_____ May we leave a Message? ☐ Yes ☐ No

Cell/Other: (_____)_____ May we leave a Message? ☐ Yes ☐ No

E-mail Address:_____ May we e-mail you? ☐ Yes ☐ No
**Please note: E-mail correspondence is not considered to be a confidential medium of communication.*

Part Two:

List all those living in the child's home:
Name: Relationship: Age:

_____
_____
_____
_____
_____
_____

List other persons closely involved in the child's life but not residing in home:
Name: Relationship: Age:

_____
_____
_____
_____
_____

What are your concerns about your child that prompted this visit?

Please describe any concerns that are listed below that your child is displaying:
Difficulty sleeping/frequent nightmares:
Bed-wetting or soiling:
Unusually clingy or immature behavior:
Excessive fears, anxiety:
Physical complaints (stomachaches, headaches)
Change in eating habits:
Little sense of joy/happiness:
Hurst self on purpose/ talks about wanting to die:
Blatant misbehavior:
Aggression towards others:
Hurts animals on purpose:
Sets fires:
Lies/steal:
Hides food:
Difficulties with peers or bullying:
Inappropriate sexual behavior:
Poor self-esteem:
Overwhelming sadness:
Overwhelming anxiety or worry:

Please describe any other concerns you have about your child:

What are your child's strengths?

Describe your child's school experience:

Does your child have an IEP or any other behavioral modifications strategies currently in place at school?

What are your child's interests and/or participation in after school activities?

Describe your child's relationship with siblings:

Describe any serious difficulties or life stresses your child has experiences and when they occurred:

_____

_____

_____

Describe your child's ability to complete tasks and follow directions:

_____

_____

_____

List any complications at birth and delays in development or difficulties when your child was an infant/toddler:

_____

_____

_____

List any ongoing health concerns/allergies:

_____

_____

List any medications and the purpose of each:

_____

_____

_____

Describe any prior assessment/therapy your child has received (Name of professional, date of services and diagnosis):

_____

_____

Who referred to treatment? (Teacher, school counselor, doctor)-

_____

Family Mental Health Inventory: *The following is to provide information about your family history. Please mark yes or no. If yes, please indicate family member affected.*

Autism Spectrum	Yes	No	_____
Attention Deficit	Yes	No	_____
Depression	Yes	No	_____
Anxiety Disorder	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Learning Disability	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____

Special Confidentiality Notice for Parents

For therapy to be successful, teenagers must be able to talk freely and comfortably, without feeling like what is shared must be censored for fear of disclosure to parents. Therefore, if your child is scheduled for individual therapy, we will not disclose information to parents without the teenager's consent unless we believe the adolescent is a danger to themselves or others. Some disclosure by teens can be extremely helpful in facilitating a trusting relationship between the teenager and parents. Therefore, we work with your child to encourage this type of disclosure. With the adolescent's consent, we will also give parents periodic updates on their therapeutic progress. Understanding that this may be new and challenging for some parents, we encourage parents to call us with any questions or concerns throughout the course of treatment.

You should know that confidentiality has limits. If there is any threat to your child's life, we have the duty to inform you and help to create a plan for safety. We will tell parents, as is required by law, if we believe the teen is a danger to themselves or others. It is important for teens to have a safe, private space to work on their goals. In addition, there are situations that we are mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse, neglect, and pregnant women who report using drugs.

Please review Wisconsin DHS Rights of Minors Brochure (paper copy available in each Hope Lobby Area) and the Official Website for Additional Information-
https://www.dhs.wisconsin.gov/clientrights/minors.htm

My signature below is an acknowledgement of the above.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Printed Name of Parent/Guardian Date