**Christina Dougherty, LCSW, LLC**

**Psychiatric Assessment, Psychotherapy & EAP Services**



**Confidentiality, Disclosure of Health Information, & Expectations for Therapy**

* I understand that Christina Dougherty LCSW, Matthew McGahran LCSW, and associates **create and maintain health records** describing my health history, symptoms, examination and test results, diagnoses, treatment, progress notes, and any plans for future care or treatment. This information serves as a basis for planning my care and treatment and may be used as a means of communication among the many health professionals who contribute to my care.
* I understand that I may request copies of my treatment record for any purpose, including my own review, but that this will be discussed and granted and/or denied on a case-by-case basis by the treating clinician and/or clinical director.
* I understand that my **health information cannot be released to any provider, agency, or individual without my written permission**, and **only in a secure manner that follows HIPPA (Health Insurance Portability and Accountability Act of 1996) guidelines**. The information verbally given in the sessions is also confidential. Once permission has been given, I understand that I can revoke this permission at any time, as well as add providers and/or other individuals at my request at any time during the treatment process. If I give a **cell phone or home phone number, I am authorizing this office permission to leave a voicemail** if contact is necessary.
* I understand that this **agreement of confidentiality can be breached by the treating clinician only in the event that I make the clear statement or indication with intent and plan that I wish to harm myself or another person** and proper authorities or individuals may be notified, but the least information deemed necessary in this event will be released. Also, if information is disclosed in the session that **either a minor or an elder person is a victim of abuse and/or neglect,** this may also be subject to exception to confidentiality as clinicians in this office are Mandated Reporters for suspected child and elder abuse under Pennsylvania Law.
* I understand that therapy is a place where strong emotions, memories, and difficulties may be shared and that I may be given some suggestions for treatment and/or assistance that may be difficult. I assume responsibility, understand that therapy is designed to help, and in **no way will I place blame or attempt legal recourse upon Christina Dougherty LCSW LCSW** or any associated therapist due to the results of any treatments or therapy.
* I understand that **I may change or cancel a scheduled appointment if I give at least 24 hours notice**; exceptions are made for emergencies by the treating clinician on a case-by-case basis. Late cancels or no shows without 24-hour notice will result in **full payment due for the session billed directly to the client; insurance will not pay for late cancels or no shows. This payment will be collected prior to being allowed to schedule the next appointment.** More than one late cancel and therapy will be discontinued, as there is often a waiting list for new clients to be scheduled.
* I understand that it is **my responsibility to arrive on time and respect the allotted therapeutic time period for the session**. This allows the therapist to serve the next appointment promptly. Adjustments will be attempted for late arriving clients, but it is possible that the session may be shortened with the expectation that the full fee will be paid for the time reserved.
* I accept that **I will pay the co-pay or agreed upon fee for my therapy at the start of my session**. Cash, check, VISA MC credit/debit card, and health care spending account cards are accepted.

Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_