THE ANXIETY & AGORAPHOBIA TREATMENT CENTER
112 BALA AVENUE
BALA CYNWYD, PA 19004
PHONE: (610) 667-6490 FAX: (610) 667-1744

Informed Consent/Rules and Limits of Confidentiality

The purpose of meeting with a psychotherapist is to get help with problems or processes that are bothering you or interfering with important areas of life. For most people, knowing that what they say will be kept private helps with disclosing thoughts, feelings, and perceptions and to have more trust in their therapist.

As a general rule, information you share in therapy sessions is confidential, unless you give consent to disclose certain information. However, there are exceptions to this rule that are important to understand prior to starting with the therapy process.

Confidentiality can be broken under the following circumstances:

1. If you report having a plan to harm yourself, based on the evaluation of that plan, in order to protect you from harming yourself.

2. If you report having a plan to harm someone else, based on the evaluation of that plan, in order to protect the person you intend to harm.

3. If you are involved in activities that could cause harm to yourself or someone else, even if you do not *intend* to harm yourself or someone else, based on the evaluation of that behavior.

4. If I have knowledge or reasonably suspect that you (any therapy client under age 18), or any child or teen (any individual under age 18) is, or has been, the victim of abuse, the law requires me to file a report with the appropriate agency.

5. If you are involved in a court case and a request is made for information about your therapy, information will be disclosed with your written consent unless the court *requires* that information be provided. If this occurs, you will be informed of the proceedings, and efforts to protect your confidentiality will be taken and discussed with you.

6. If you agree that information can be shared with a specific person or entity, then we will discuss the limits of what will be shared, and how that information will be shared.

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For children/teens under age 14:

The parent(s)/legal guardian(s) are legally entitled to disclosure of material from the therapy sessions. Limits of confidentiality apply as described above.

For teens ages 14-18:

Except for situations as described above, your parents/guardians will not be told of specific information you disclose in therapy. *This includes activities and behavior that your parents/guardians may not approve of or be upset by, but that do not put you or others at risk for immediate harm.* It may be important to let your parents know some information that is protected by confidentiality and you may be encouraged to share that information. Part of the therapist's job is to discuss this with you and to decide together the best way to communicate the information.

Parents and guardians may be able to be more helpful if they have general ideas about themes of therapy and the therapist may discuss with your parent(s) specific suggestions that do not involve breaking your privacy. Parents are strongly urged to respect the privacy of your treatment and the related records.

Billing/scheduling: By signing this form you also give permission for the therapist or office staff to release information to and/or to contact your parent(s)/guardian(s) about billing/scheduling. On the following line, please list the names of responsible parties that we may release information to regarding billing and scheduling: _____

Below, you are asked to sign this form, as are your parents/guardians. You can be given a copy of this if you would like.

In signing this document, I give my permission and consent to the Anxiety and Agoraphobia Treatment Center to provide psychotherapeutic treatment to me and/or _____, who is my child.

I understand the rules and limits of confidentiality.

I understand that the Anxiety and Agoraphobia Treatment Center does not provide 24-hour crisis services. In the event of an emergency, I understand that I should call 911 or go to the nearest emergency room.

I accept responsibility for payment in full for all services rendered at the Anxiety and Agoraphobia Treatment Center. I understand at least 24 hours notice is required to cancel or change an appointment or I will be charged for the time.

Client's Signature (ages 14-adult):

Signature_____Date _____

For children (under age 14) and teens (ages 14-18) parents should also sign below:

Parent Signature _____Date_____

Parent Signature _____Date_____

Witness Signature _____Date _____