

# Door of Hope Counseling

1201 N Watson Road Suite 177

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*Cynthia A. Thompson, M. Ed., LPC-S*

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## **Confidentiality & Limitations**

All identifying information about your therapeutic treatment is kept confidential. Information solicited by phone, written, or in person regarding my clients will not be provided unless prior consent is given. I will ask you to sign a consent form to release or obtain information before any information is provided to any third party. This condition applies also in cases where coordination of treatment is necessary with another health-care professional (physician or psychiatrist). However, there are exceptions and/or limitations to confidentiality. The following are limitations to confidentiality:

- to seek professional consultation.
- if the therapist suspects that a person has intentionally or unintentionally abused or neglected the care of a child, a disabled person, or an elderly person. Such cases of suspected abuse are reported to the appropriate protective agency for investigation and intervention.
- if the therapist suspects that the client may be likely to harm himself/herself or another person. In these cases reporting to appropriate agencies for intervention may break confidentiality.
- if you disclose having had sexual contact with another treating health professional.
- if you sign a Release of Information Form.
- if a Court orders disclosure of the records.

## **Individual, couples, and family confidentiality**

When I work with you individually, you hold the right to confidentiality. When I am working with couples, I am obligated to preserve confidentiality on behalf of the couple. This means that I will not release any information about either member of the couple without the consent of both. This also means that I will not hold individual confidences of either party that will jeopardize my allegiance to both parties in the couple.

When working with an adolescent, the parents hold the right to confidentiality from a legal perspective. From a clinical perspective, I will not discuss the contents of counseling sessions. This would interfere with the need to establish trust and rapport with the child. However, if a child or an adolescent, discloses anything that makes me seriously concerned about his/her safety and well-being or the safety and well-being of someone else, the adolescent's only choice regarding confidentiality is to participate or not to participate with me in sharing the information with his/her parents.

***I understand the limitations to confidentiality described above.***

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

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Counseling



**Notice of Privacy Practices**

The *Notice of Privacy Practices* provides information about the use and disclosure of your personal health information (PHI). As part of your healthcare, your therapist originates and maintains health records describing your health history, symptoms, evaluations and test results, diagnosis, treatment and any plans for future care or treatment. This information may be used to plan your care and treatment, to communicate to other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals. All records, whether written, oral or in electronic format, are confidential and cannot be disclosed without your prior written authorization, except as otherwise provided by law. You have the right to restrict the use and/or disclosure of your PHI for treatment, payment, or healthcare operations. You may revoke consent at any time in writing.

***I understand and have received a copy of the above Privacy policy.***

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date