Denise Fitzpatrick, M.Ed., LMHC
1350 Main Street
Walpole, MA 02081
617-694-7015

Confidentiality and Informed Consent to Treatment

Your Therapist
Denise Fitzpatrick is a licensed mental health counselor engaged in private practice providing mental health care services. The purpose of receiving mental health care services is to help you better understand your situation, change your behavior or move toward resolving your difficulties. It will be important for you to examine your own feelings, thoughts and behavior, and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you feel it would be helpful or if this is recommended by Denise Fitzpatrick.

The services I offer can have benefits and risks. Since treatment often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health care services have also been shown to have benefits for people. Treatment may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Appointments
Appointments are made by calling (617) 694-7015. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Appointments are 50 minutes in length, but may vary for clinical reasons.

Relationship
Your relationship with Denise Fitzpatrick is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that Denise Fitzpatrick not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Denise Fitzpatrick cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you.

Goals, Purposes and Techniques
There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by Denise Fitzpatrick and to have input into setting the goals of your therapy. As therapy progresses, these goals may change. You and Denise Fitzpatrick will jointly determine how to effect the changes you are seeking to make for yourself.

Confidentiality
The law protects the privacy of all communications between a client and a therapist. In most situations, Denise Fitzpatrick Counseling can only release information about your treatment to others if you sign a written authorization form. There are some situations where we are permitted or required to disclose information either with or without your consent or authorization. For example,

- *If you are involved in a court proceeding and a request is made for information concerning your treatment, we cannot provide such information without your (or your legal representative's) written authorization, or a court order.*
- *If a government agency is requesting the information, we may be required to provide it.*
- *If you file a complaint or lawsuit against me, I may disclose relevant information about you in order to defend the therapist.*
- *If you file a worker's compensation claim, we must, upon appropriate request, provide a copy of your records or a report of your treatment.*

There are some situations in which the therapist is legally obligated to take actions which she or he believes are necessary to attempt to protect others from harm, and we may have to reveal some information about a client's treatment. If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary.

• If your therapist has reason to believe that a child or vulnerable adult is being neglected or abused, the law requires that the situation be reported to the appropriate state agency.
• If the therapist believes you present a clear and substantial danger of harm to yourself or and/or others, he or she will take protective actions. There may include contacting family members, seeking hospitalization of you, notifying any potential victim(s), and notifying the police.

Professional Records

The laws and standards of our profession require that I keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem affects your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone.

You may examine and/or receive a copy of your Clinical Record, if you request it in writing, except in unusual circumstances that involve danger to yourself and/or others or when another individual (other than another health care provider) is referenced and we believe disclosing that information puts the other person at risk of substantial harm.

Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I therefore recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. In addition, as your therapist, I may also keep a set of psychotherapy notes which are for my own use and designed to assist me in providing you with the best treatment. These notes are kept separate from your Clinical Record. They are not routinely released to others with your Clinical Record, except in rare legal circumstances.

Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information we will discuss the matter with you, if possible, and do our best to handle any objections you may have.

Authorization to Warn or Inform Third Parties

In the event that Denise Fitzpatrick reasonably believes that I am a danger, physically or emotionally, to myself or another person, by signing this Client Information and Acknowledgment of Informed Consent to Treatment, I specifically consent for Denise Fitzpatrick to attempt to warn the person in danger and to attempt to contact any person in a position to prevent harm to myself or another person., in addition to medical and law enforcement personnel.

This information is to be provided at my request for use by said persons only to prevent harm to myself or another person. This authorization to Warn or Inform Third Parties shall expire upon the termination of my therapy with Denise Fitzpatrick.

I acknowledge that I have the right to revoke the above authorization to warn or inform third parties, in writing, at any time to the extent that Denise Fitzpatrick has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could still be permitted by law.

Telephone & Emergency Procedures
If you need to contact me between sessions, please leave a message at (617) 694-7015 and your call will be returned as soon as possible. I check my messages regularly during the daytime unless I am out of town. If an emergency situation arises, indicate it clearly in your message, and if you need to talk to someone right away call the Riverside Crisis Team: (781) 769-8674, or the Police: 911. Please do not use e-mail for emergencies, as I may not check them regularly during the day.

Consent to Treatment
I, voluntarily, agree to receive mental health care, treatment, or services and authorize Denise Fitzpatrick to provide such care, treatment or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through Denise Fitzpatrick Counseling at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Client Information and Acknowledgment of Informed Consent to Treatment Form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

These three pages are yours to keep.

Denise Fitzpatrick, M.Ed., LMHC
503 Main Street
Medfield, MA 02052
617-694-7015

Client Information and Acknowledgment of Informed Consent to Treatment

Your signature indicates that you understand and accept the information contained in the three-page document "Client Information and Acknowledgement of Informed Consent to Treatment".

Client Name:

____

Client Signature & Date:

____

Parent or Guardian Signature (for minor child):

____

Witnessed by:

____

Date:

____