Restoration Counseling Service
LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

Associate Confidentiality

As an associate (Nathaly Chavez, AMFT 109904), I will be sharing some of your information with my supervisor, Tami Miller. This will add a level of accountability and help me to be a better therapist for you. At times, it may be beneficial for our session to be recorded and reviewed by myself and my supervisor, in order to improve the services you receive. This team approach is at no additional cost to you, but does require your consent. If you consent to audio recordings of our sessions, the audio will not include any identifying information or names and will be deleted immediately after review. Consent granted ____. Consent denied ____.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

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

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full fee is charged for missed appointments or no show cancellations with less than a 24 hour notice (48 hours for a Monday appointment) unless due to illness or an emergency. A bill will be generated for all clients who do not show up for or cancel an appointment. Thank you for your consideration regarding this important matter.

_____

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

EMAIL POLICY

I often like to connect with my clients through email to encourage and educate them in regard to the challenges they are facing. In addition, I may have articles and/or resources that may be of some help which I would like to send through email.

If you would like to give your consent for these emails, please sign your name below.

_____

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