KINGSBURY COUNSELING | Josh Kingsbury, Ph.D.
LICENSED PSYCHOLOGIST

251 Woodford Street
Portland, ME 04103
(207) 773-2828 x107
josh@kingsburycounseling.com
www.kingsburycounseling.com

Couples Counseling Initial Intake Form

Please note that while you will be asked to talk about your answers in session, your partner will not be shown this form. Please fill out one version of pages 1-8 per person. You can both sign and initial one copy of pages 9-22.

Name		Intake Date				
Date of Birth	Age	F	M	MtF	FtM	
		Relationship Status				
Street Address		City/State/Zip				
Cell Phone		Okay to leave message?		Y	N	
Home Phone		Okay to leave message?		Y	N	
Work Phone		Okay to leave message?		Y	N	
Email		Okay to contact via email?		Y	N	
Our scheduling program allows us to send out appointment reminders by email. Would you like to receive these? (This is recommended)				Y	N	
Preferred method(s) of contact						
Cell	Home	Work	Email	Text		
Ethnic/Racial Identity		Sexual Orientation				
Occupation		Employer/School				
Spiritual Orientation		Referred by				

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Billing Information for Responsible Party

Name	Relation to client	
Date of Birth	Phone	
	F	M
Street Address	City/State/Zip	
Insurance Company	Insurance Company Phone	
Policy Number	Group Number	
Insurance Plan Name	Managed Care Authorization Number	
Employer		

*If you will be using your partner's insurance information, this only needs to be completed on their form.

Emergency Contact Information

Name	Relation to client		
Phone #1	Okay to leave message?	Y	N
Phone #2	Okay to leave message?	Y	N
Email	Okay to contact via email?	Y	N
Street Address	City/State/Zip		
Providing this information does not give us consent to reach out to them. Please fill out and sign the attached Authorization for Release of Information form included in this packet to allow me to do that.			

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Relationship Status: (check all that apply)

☐ Married ☐ Living Together ☐ Divorced

☐ Separated ☐ Living Apart ☐ Dating

Length of time in current relationship? _____

What do you hope to accomplish through counseling?

_____

_____

_____

What have you already done to deal with the difficulties?

_____

_____

_____

What are your biggest strengths as a couple?

_____

_____

_____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1 2 3 4 5 6 7 8 9 10

(extremely unhappy) (extremely happy)

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does:

_____

_____

_____

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Have you received prior couples counseling related to any of the above problems?

Have either of you been in individual counseling before? ☐ Yes ☐ No

If so, please give a brief summary of the concerns you addressed.

Do either you or your partner drink alcohol or take drugs to intoxication? ☐ Yes ☐ No

If yes for either, who, how often, and what drugs or alcohol?

Do you ever wish your partner would cut back on his/her drinking or drug use? ☐ Yes ☐ No ☐ N/A

Have either your or your partner stuck, physically restrained, used violence against or injured the other person? ☐ Yes ☐ No If yes, who, how often, and what happened?

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?

☐ Yes ☐ No If yes, who? ☐ Me ☐ Partner ☐ Both of us

If married, have either you or your partner consulted with a lawyer about divorce?

☐ Yes ☐ No If yes, who? ☐ Me ☐ Partner ☐ Both of us

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Do you perceive that either you or your partner has withdrawn from the relationship?

☐ Yes ☐ No If yes, who? ☐ Me ☐ Partner ☐ Both of us

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10

(extremely unpleasant) (extremely pleasant)

How satisfied are you with the frequency of your sexual relations? (Circle one)

1 2 3 4 5 6 7 8 9 10

(extremely unsatisfied) (extremely satisfied)

What is your current level of stress (in the relationship)? (Circle one)

1 2 3 4 5 6 7 8 9 10

(no stress) (high stress)

What is your current level of stress (overall)? (Circle one)

1 2 3 4 5 6 7 8 9 10

(no stress) (high stress)

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Couple Satisfaction Checklist

Place a check in the box to the right of each relationship category that best describes how satisfied you feel.

	Very Dissatisfied	Moderately Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Moderately Satisfied	Very Satisfied	Check 3 areas you most want to change
Degree of Closeness, Openness, Confiding, Sharing and Comforting							
Expression of Affection and Caring							
Satisfaction with Sexual Intimacy							
Handling Conflicts and Arguments							
Expression of Anger, Criticism or Blame							
Handling Family Finances							
Handling of Parenting Issues							
Handling of Household Tasks							
Common Interests and Social Life							
Degree of Respect and Admiration for Your Partner							
Satisfaction with Your Role in the Relationship							
Satisfaction with Your Partner's Role in the Relationship							
Overall Satisfaction with Your Relationship							

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Lastly, please draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Note *pivotal/significant events* in your relationship (e.g., one of you moved out, one of you cheated).

Complete satisfaction

No satisfaction

Relationship over time

When you met/began dating ***Current***

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Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION ACCORDING TO THE HEALTH INSURANCE PORTABILITY ACT OF 1996 (HIPAA). PLEASE REVIEW IT CAREFULLY.

I may *use* or *disclose your protected health information (*information in your health record that could identify you or PHI), for *treatment, payment, and health care operations* purposes with your *consent.*

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

"PHI" refers to information in your health record that could identify you.

"Treatment, Payment and Health Care Operations " - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

"Payment" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

"Health Care Operations" are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

"Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing.

You may not revoke an authorization to the extent that (1)1 have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

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I will also obtain an authorization from you before using or disclosing:

· PHI in a way that is not described in this Notice.

· Psychotherapy notes

· PHI for marketing purposes, such as sending a list or newsletter of helpful services to my clients

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I have a reason to suspect that a child has been abused or neglected, I am required by law to report this to the Office of Child and Family Services.

Adult and Domestic Abuse: If I suspect or have a good faith reason to believe that any incapacitated adult has been subject to abuse, neglect, self neglect or exploitation, or is living in hazardous conditions, I am required by law to report that information to the Commissioner of the Department of Health and Human Services.

Health Oversight: If the Maine Board of Psychological Examiners is conducting an investigation, then I am required to disclose your mental health records upon receipt of a subpoena from the Board.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I provided you and/or the records thereof, such information is privileged under state law, and I may not release information without your written authorization, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance, if this is the case.

Serious Threat to Health or Safety: If you have communicated to me a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or if you have made a serious threat of substantial damage to real property, I am required by law to take reasonable precautions to provide protection from such threats by warning the victim or victims of your threat, and to notify the police department closest to your residence or the potential victim's residence, or to obtain your civil commitment to the state mental health system.

When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and Maine's confidentiality law: This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDG-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations -You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me.

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Upon your request, I will send your bills to another address.)

Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting- You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket - You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

Right to Be Notified if There is a Breach of Your Unsecured PHI - You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Psychologist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will post a current copy of this Notice in my office and will provide you with a paper copy with the new effective date on request.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the Office for Civil Rights, which can be reached at (617) 565-1340. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Restrictions and Changes to Privacy Policy

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain.

Your signature below indicates that you have read and received a copy of this information.

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If you are part of a couple or family, please each print and sign your name below as space is available.

Client's Printed Name Date

Client's Signature Date

Client's Printed Name Date

Client's Signature Date

Printed Name of Parent/Guardian if Client is Under 18 Date

Signature of Parent/Guardian if Client is Under 18 Date

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Psychotherapy Services Agreement

This agreement contains important information about my professional services and business policies. Please read it carefully and discuss with me any questions you may have at your first meeting. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time.

PSYCHOLOGICAL SERVICES:

Psychotherapy is not an exact science. Psychotherapy outcome research over the last two decades indicates that as a result of therapy, most individuals feel better and function better in a variety of areas after treatment. I approach psychotherapy with clients as a collaborative process where we work together to identify concerns and address areas for growth. I hope that as you make progress during your therapy sessions, you also learn skills that you can take outside your sessions to continue your personal growth.

The process of psychotherapy can at times be uncomfortable, as you may be addressing issues that feel upsetting or increase your anxiety. You may also experience discomfort or resistance to changes you are making from people in your life who have been accustomed to these dynamics you are now changing. Success in therapy is dependent upon many factors, including being motivated to change, having open communication between you and your therapist, working with a therapist who agrees with you about the major issues to be addressed in therapy, attending sessions regularly, and considering before each session what you want to discuss.

Psychotherapy is different from a medical appointment with a physician. It involves a significant commitment of time, effort and money on your part. We will spend some time identifying the major problems and goals that concern you and discuss a specific time frame within which to accomplish these goals. The length of time that people are in treatment will vary greatly. Some people may achieve their goals within a few weeks/months. Others may need to be in treatment for years, especially when their problems have been present for many years. I cannot guarantee how long treatment will last, nor can I guarantee a specific outcome. There are risks to being in psychotherapy, including the unlikely possibility that your symptoms will simply get worse. Most clients find that their symptoms may get worse before they get better. If you have questions about this, please don't hesitate to ask me.

Our first few sessions will involve an evaluation of your needs. At the end of this period, I will be able to offer you some first impressions what our work will include and a treatment plan to follow if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be careful about the therapist you select. If you have questions about my approach or procedures, we should discuss them when they arise.

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If your doubts persist, I will be happy to help you set up a meeting with another mental health professional.

Although I share office space with other mental health professionals, this is not a group practice; each of us operates independently and many of us utilize different business names. I am not responsible for any services provided by other professionals within the office, nor are they responsible for my services.

MEETINGS AND CANCELLATIONS:

I normally conduct an evaluation that will last from 1 to 3 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute session per week at a time we agree on, although we may decide to meet more or less frequently.

Once an appointment hour is scheduled, you will be expected to pay for the session unless you provide 24 hours advance notice of cancellation. Without a notification, fees will be charged to you (not your insurance company) as follows:

- Cancellations within 24 hours of the appointment: $75
- No-shows (missed appointments without notification): $125

You may avoid a cancellation or no-show fee if we are able to reschedule within the same week as dictated by my schedule and availability. Please note that insurance companies do not provide reimbursement for cancelled or missed sessions.

It is important that you are on time for appointments. Because of scheduling for other clients, sessions will end at the scheduled time and arriving late will interfere with the amount of time you have for your appointment. If frequent cancellations, last minute rescheduling of sessions, or no-showing for appointments interferes with our work together, I reserve the right to stop providing services and close your file. In such cases, I will be happy to provide appropriate referrals to meet your needs.

If you decide to end your therapy before reaching treatment goals, please notify me of this decision. I will be happy to provide appropriate referral information as needed. If you miss a session or do not reschedule and I do not have any contact with you for a month I will assume that you have decided to stop therapy and will close your file. At that point I will no longer be responsible for your care. In any event, once you have been terminated whether a planned termination or termination because of cancellations, rescheduling, no-shows, etc., I will no longer be responsible for your care. In most cases, we can easily resume therapy after closing a file.

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PROFESSIONAL FEES:

Fees for my services are as follows unless we have discussed alternative arrangements:

- Individual Intake: $150
- Couples Intake: $175
- Individual Therapy: $125 for a 45-minute session, $135 for a 55-minute session
- Couples Therapy: $140 for a 55-minute session.
- Psychological Assessment: $150 per hour. Depending on the type of assessment, this may range up to $1500-$2000 (often out-of-pocket depending on your insurance)
- Administrative Tasks: $100 per hour, prorated in 15-minute intervals. This includes email, telephone conversations with you or others whom you have authorized to speak with on your behalf, and any other tasks you ask of me outside of our scheduled session
- Legal Proceedings: $200 per hour for preparation and attendance of any legal proceeding

Payment or your copay is due at the time services are rendered.

BILLING AND PAYMENTS:

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your insurer determines that they will not pay for services, you are ultimately responsible to pay for services. Payment that is not made at the time of a session is generally expected within 30 days. I am happy to work with patients to arrange for payment plans if that becomes necessary.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using a legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action becomes necessary, the costs will be included in the claim. In most collection situations, the only information I release regarding treatment is the client's name, the nature of the services provided (i.e. individual psychotherapy), and the amount due.

INSURANCE REIMBURSEMENT:

In order for us to set realistic goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive benefits to which you are entitled; however, you

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(not your insurance company) are responsible for full payment of my fees. It is important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clarify benefit, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require pre-authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some clients feel they need more services after insurance benefits end. (Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.)

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I am required to relate additional clinical information such as treatment plans or summaries, or copies of your entire record (in rare cases). This information will become part of the insurance company's files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical databank. I will provide you with a copy of any report I submit, if you request it.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your treatment. It is important to remember that you always have the right to pay for my services yourself to avoid these problems that compromise your full confidentiality.

PROFESSIONAL RECORDS:

The laws and standards of my profession require that I keep Protected Health Information about you in your clinical record. This record contains forms you have signed (including this one), an assessment, a treatment plan, and notes about our meetings. I may also have records that you have authorized to be sent to me from other providers. All of this information is kept in a locked

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filing cabinet in my office.

You have the right to examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. Clients may be charged an appropriate fee for any professional time spent in responding to information requests, including $1.00 per page for the first 25 pages and 25 cents for each page thereafter, as well as postage or other costs associated with furnishing these records.

CONFIDENTIALITY:

Under Maine law, communication between a client and a licensed Psychologist is privileged (confidential) and, in general, may not be disclosed to anyone without your prior written consent. There are, however, some exceptions to your confidentiality. Even without your consent, I am legally obligated to report certain disclosures you may make. For instance, **I may be required** to disclose certain information if:

- There is a serious threat of physical violence to yourself (e.g., suicide threats) or a third party or a serious threat of substantial damage to real property. If you are threatening to harm yourself, I am required to take whatever actions seem necessary to protect your and/or others from harm. If I have serious concern about your intention to harm yourself or someone else, I may require you to go to a hospital emergency room for evaluation. If you refuse, I would be required to notify the appropriate authorities, and/or the potential victim, to ensure that you get the treatment that you need.

- There is reason to suspect that a minor child (under age 18) or an incapacitated adult is being or has been subjected to abuse or neglect by you or someone else. If someone tells me of knowledge of active abuse of his/her own child or another child or an elder, I cannot keep this information confidential.

- There is an allegation that you have been subjected to sexual misconduct in the course of a previous mental health counseling relationship.

- I receive a valid subpoena or court order requiring the disclosure of all or some part of your counseling record. If I am ordered by the court to disclose information, I am legally obligated to do so.

- If the ME Board of Mental Health Practice or the ME Department of Health and Human Services are conducting investigations, I will be required to cooperate and allow access
to your records.

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- If treatment involves others close to you, such as your parents, spouse, or child(ren), then I will work to clarify our role in relation to each person. In most cases, there is only one identified client, and my responsibilities will be to that person. There are exceptions, such as when I may provide couples counseling to more than one person, in which case the *relationship* is the "client" and therefore I cannot "take sides" with one party (e.g., testify for one or the other in divorce or child custody disputes).

- If you use health insurance to pay for any portion of your treatment, I may be required to release some details about treatment to you insurance company.

- Sometimes I may utilize the services of office managers to assist with scheduling, billing, and other clerical duties. These professionals are bound by the same confidentiality requirements as I am and are not allowed to release confidential information without written consent.

- I am also professionally and ethically required to consult with other psychologists regularly. Such consultations are bound by the same confidentiality as are individual sessions. Should I decide to consult about your case, I will omit identifying information from such consultations to protect your privacy. If you object to my consulting with colleagues about your situation, please inform me so that I can understand your concerns.

In those rare instances where it is necessary for me to disclose information relating to your counseling without your permission, I will make every effort to fully discuss it with you. However, when I am required to disclose your records pursuant to a court order issued under the Patriot Act, I may be prohibited by the terms of the order from notifying you of the disclosure.

Please see the final sections for information about confidentiality and how that differs around minors and couples/families seeing me for therapy.

CONTACTING ME:

I am often not immediately available by telephone, as I do not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voicemail. I check for messages frequently and I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays or when I have indicated that I will be away from the office for extended periods of time. If you are difficult to reach, please inform me of times when you will be available.

I may be reached in emergencies by calling my cell phone (207) 370-2823. **If you are experiencing a crisis and cannot reach me immediately, please call 911 or go to your nearest emergency room**. You can also contact Cumberland County Mobile Crisis at (207) 774-Help or the Maine Crisis Line at 1-888-568-1112.

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If one or both of us is aware that you may require care with greater emergency availability, I will help you identify other area resources to better meet your needs.

For non-crisis communications, such as scheduling and billing issues, you may also choose. My email address is josh@kingsburycounseling.com. Please note I am unable to discuss clinical information over email.

I do not initiate email contact with clients. I do allow clients to make appointment changes using email but encourage people to be aware that electronic means of communication cannot be guaranteed to be confidential. I do not use email to communicate about therapy issues or to provide psychotherapy interventions.

YOUR RIGHTS:

As a consumer of mental health services, you have the right to:

1. Have full and complete knowledge of your therapist's qualifications, training, and licenses.
2. Be fully informed regarding proposed evaluation and treatment.
3. Discuss your therapy with anyone you choose, including another therapist or mental health provider.
4. Refuse treatment entirely, or any component of any proposed treatment arrangement.
5. Request that information from your treatment be shared with another therapist or organization, provided that appropriate consent forms have been signed.
6. Question your therapist's competence. Should you become displeased with services, you are encouraged to talk to me to see if the matter can be resolved. If you feel unable to address these concerns with me, you may address these concerns with another therapist or pertinent professional or legal bodies.
7. Request copies of ethical principles or other guidelines that govern my practice.

MINORS & PARENTS:

The law allows parents or legal guardians of unemancipated clients under 18 to examine their child's Clinical Record unless I decide that doing so is likely to cause harm or injury to the child. It is my policy to request an agreement from parents (available on my website or by request) that they allow clinical information to remain confidential unless I believe that the child is in danger. If parents agree, I will provide them only with general information about the progress of the

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child's treatment. However, even with this agreement in place, parents have the right to review their child's records. If information is disclosed to parents, I will attempt to discuss the matter with the child and do my best to handle any objects he or she may have.

If you are a legal minor (i.e., a non-emancipated person under 18 years of age) or you otherwise have one or more legal guardian(s), then your legal guardian(s) is(are) considered by law to be the one(s) responsible for making treatment decisions, including decisions about what access is allowed to your Clinical Record.

COUPLES & FAMILIES:

This written policy is intended to inform you that when I agree to work with a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (the treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. Please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required to do so or unless I have your written authorization. I consider these sessions part of the family or couple therapy. I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session with the entire treatment unit if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit. I often will encourage the individual or the smaller part of the treatment unit being seen to make the disclosure themselves.

Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you may wish to consult with a therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the patient (the couple or the family unit) by preventing a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during the therapy, I might be placed in a situation where I will have to terminate the treatment of the couple or the family.

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This policy is intended to prevent the need for such a termination.

EMAIL COMMUNICATIONS:

I use email communication only with your permission and only for administrative purposes, unless we have made another agreement. That means that email exchanges with my office should be limited to things like setting and changing appointments, billing matters, and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session.

TEXT MESSAGING:

Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to, nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.

SOCIAL MEDIA:

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of causal social contract can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

WEB SEARCHES:

After we begin our professional relationship, I will not use web searches to gather information about you without your permission. I believe this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

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Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professional cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

TELEPSYCHOLOGY:

As telepsychology involves a different set of requirements that are not applicable to everyone, I have a separate form for this service. If you would like to participate in telepsychology, please let me know and we can discuss it further. I have placed the separate consent form for telepsychology on my website (https://www.kingsburycounseling.com/forms/). You can also request a copy from me.

Some clients like to have the option for telepsychology open for them on the occasions that they may be sick and unable to attend a session or that inclement weather keeps them from attending sessions. If you would like to have this as an option, let's discuss this. Maine has been a state that requires insurance plans to operate under "parity" which means they should cover teletherapy for you if they would have covered an in-office visit. Sometimes they still deny claims on a technicality. It is important for you to check with your plan to determine if yours accepts telepsychology as I am unable to check this information for you on short notice.

Please note that the Maine licensing board considers telepsychology to occur where the client is, not where my office is. Therefore, I can only do telepsychology with someone who is physically in the state of Maine.

This document is effective as of 1/1/2014. Its latest update was 11/15/2018.

KINGSBURY COUNSELING | Josh Kingsbury, Ph.D.
LICENSED PSYCHOLOGIST

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Your signatures below indicate that you have read this agreement and agree to its terms, that you have read and understood the above risks and benefits of psychotherapy, and that you give your consent to participate in treatment. Please print off additional blank copies of this page and sign as needed for couples or families.

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

I have received the HIPAA Privacy Policy (Notice of Privacy Practices included in packet).

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

I understand Dr. Kingsbury's policy for missed appointments and that I may be responsible for my usual session fee if I do not provide 24 office hours notice of cancellation. I also understand that most insurance companies do not reimburse for cancelled or missed sessions.

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

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Authorization for Release/Request of Confidential Information

FOR EMERGENCY CONTACT

Permission is hereby given to Josh Kingsbury, Ph.D. to release and/or exchange information for professional use from the records of:

Client Name:_____

This authorization includes the release of psychological and/or psychiatric information which may be part of the medical record.

The type of information is limited to (check at least one):

[ ] any and all information
[ ] discharge summary/report
[ ] psychological evaluation(s)
[ ] confirmation of services

[ ] treatment summary
[ ] drug and alcohol issues

[ ] intake summary/report
[x] other: information needed in an emergency situation

[ ] with the following exceptions_____

The information should be released to, received from, and/or exchanged with:

Name:_____

Address:_____

Telephone/Fax:_____

This authorization shall remain in effect until: _____

I understand that I may revoke this consent at any time by notifying my therapist, Josh Kingsbury, Ph.D., in writing. I also hereby release Josh Kingsbury, Ph.D., from any liability in connection with the release of the above information.

Client Name:_____ Date of Birth:_____

Address:_____

Signature:_____ Today's Date:_____

Dr. JoshKingsbury:_____ Today's Date:_____

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Authorization for Release/Request of Confidential Information

FOR PRIMARY CARE PROVIDER (IF APPLICABLE)

Permission is hereby given to Josh Kingsbury, Ph.D. to release and/or exchange information for professional use from the records of:

Client Name:_____

This authorization includes the release of psychological and/or psychiatric information which may be part of the medical record.

The type of information is limited to (check at least one):

[x] any and all information
[ ] discharge summary/report
[ ] treatment summary
[ ] intake summary/report
[ ] psychological evaluation(s)
[ ] confirmation of services
[ ] drug and alcohol issues
[ ] other:_____

[ ] with the following exceptions_____

The information should be released to, received from, and/or exchanged with:

Name:_____

Address:_____

Telephone/Fax:_____

This authorization shall remain in effect until: _____

I understand that I may revoke this consent at any time by notifying my therapist, Josh Kingsbury, Ph.D., in writing. I also hereby release Josh Kingsbury, Ph.D., from any liability in connection with the release of the above information.

Client Name:_____ Date of Birth:_____

Address:_____

Signature:_____ Today's Date:_____

Dr. JoshKingsbury:_____ Today's Date:_____