Consent to Treatment / Confidentiality Policy

(Confidential)

All therapists at The Peacemaker Center are experienced and professionally trained. I/We understand the relationship established with our therapists is voluntary and I/we have the right to end the relationship at any time. All client information and client records are strictly confidential. Information is shared only with authorized professional staff, including clinical supervisors, and the persons I/we have listed below. The only exceptions to this policy are as follows:

- If our staff has reason to believe that a child has been physically or sexually abused, we are required by law to report it to the state protection service. We are not making a determination that any behavior is unlawful or improper. That determination is made by the state.

- If our staff has reason to believe that a client may seriously harm him/herself or another person, we are required to release information to protect the person who may be harmed.

- Selected records may be made available to certifying or licensing organization for review of our record-keeping procedures.

- If information is shared during an individual counseling session that will impact the couples' therapy or relationship, the therapist may share that information with the spouse/partner. Either spouse/partner may choose to end couple's therapy and begin individual therapy, at which point, information shared would be confidential, even from the spouse/partner.

- If you choose to have electronic therapy, using cell phones, email, video conferencing, etc. please understand the security risks that are included. The Peacemaker Center therapists will do their best to ensure confidentiality and security, but with technology, confidentiality and security cannot always be guaranteed.

- Children under the age of 14 need signed parental consent from both parents or all legal guardian(s) for treatment.

In the treatment of a couple or a family, The Peacemaker Center will seek the authorization of all member of the treatment unit before the release of confidential information to third parties. I/We understand in order to protect confidentiality, any inquiries other than the below-mentioned exception (written, telephone or personal) will not be answered until I/we sign a separate release of information.

I/We allow the following person to hear conveyed information from counseling sessions:

_____

(Continued other side)

Litigation Limitation

As a participant in therapy at The Peacemaker Center I/we understand and agree that no employee, agent, or principal of The Peacemaker Center shall be called as a witness to testify on our behalf, or on behalf of our children in any legal proceedings concerning my/our therapy. Further, I/we understand and agree for myself/ourselves, and for those who would represent us, that no documentation, other than recommendations, prepared in conjunction with The Peacemaker Center shall be subject to subpoena or records deposition for use in legal proceedings. I/we understand that this provision is necessary in order to foster frank, open, and meaningful exchanges between myself/ourselves and my/our therapist. I/We understand that I am/we are giving up our right to use testimony, records, or other information contained at The Peacemaker Center, but that I/we do so voluntarily, and without undue influence, for the purpose of establishing confidentiality and privilege for myself and The Peacemaker Center, which right and privilege shall not hereafter be revoked by me or my legal representative. I/We understand that the only communication between The Peacemaker Center and/or Court will be limited to a form letter stating when the services were begun and/or whether the client completed, did not complete, or are still undergoing therapy

Payment Policies / Fee Scale

I/We accept financial responsibility for all charges incurred during services provided by The Peacemaker Center, including bank fees for returned checks. I/We understand the payment policies for private sessions and that full pay is $125 per session. Since the therapist's time has been reserved, full payment of determined fee is expected for no shows and cancellations with less than 24-hour notice. I/We understand that for my sessions my therapist has determined a **fee of $_____**.

I/We acknowledge by our individual signatures below, that each of us has read this policy, that I/we understand it and have had an opportunity to discuss its content and that I/we enter therapy in agreement with this policy.

Office Location: Downingtown □ Kennett Square □ West Chester □ Coatesville □
Audubon □ Ft Washington □

_____	_____	_____
Date	***PRINT Client Name***	***SIGN Client Name***
_____	_____	
PRINT Parent or Guardian Name	***SIGN Parent or Guardian Name***	
_____	_____	
PRINT Parent or Guardian Name	***SIGN Parent or Guardian Name***	
_____	_____	
PRINT Therapist Name	***SIGN Therapist Name***	