THE SIBLEY GROUP
Positive psychotherapy for families, couples & adults

THERAPY AGREEMENT & NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS

Welcome to our practice! We are committed to providing you with high quality services, to respecting your rights, and to recognizing your responsibilities as a client. Please read the following to become acquainted with certain aspects of a private psychotherapy practice. Upon reviewing, please sign, date, and return a copy of this agreement to your treating therapist.

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I/We understand that the following services are being provided for the emotional health of me, my relationships/family, and/or my child(ren). Our therapists use professional approaches such as: talk therapy, play therapy, sand tray therapy, cognitive behavioral treatments, expressive/art-based therapies, brain-based therapies and mindfulness strategies, couples/family approaches, parent work, and many individual therapy methods. Our therapists also provide education about behavior, mental health conditions, and coping strategies. Our therapists sometimes assign "homework" or "take home strategies" to do between sessions in order to enhance treatment. I/We understand that a "cure" is not guaranteed and that sometimes intense emotions emerge as the therapy process begins to address the issues at hand, which can result in behaviors, conflict or symptoms to increase. Treatments are designed to work with these issues over time to help you, your family, your relationship feel and work better in your lives. Please communicate directly and regularly with your therapist throughout the therapy process.

I/We also understand that therapists at The Sibley Group are licensed, independent mental health providers, and are not required to receive clinical supervision. In an effort to provide high quality services, we often participate in peer consultations, regular supervision meetings, and consult with legal or clinical experts. We also cover for each other in emergency or leave situations. We understand that therapists who are not independently licensed are supervised regularly in compliance with DC regulations. In these consultative discussions, our therapists make every effort to keep identifying information confidential.

I/We also understand that I/we have the right to participate in treatment decisions made on our behalf or on the behalf of my child(ren). TSG Therapists will periodically review and revise a treatment plan that includes goals, interventions, and timeframes for completion. I/We understand that we have the right to refuse the recommended treatment and that I/We may withdraw this consent to treat.

1. **Services provided**
   This agreement documents and describes the services rendered by the therapists of The Sibley Group, also known as Allison & Sibley Associates, LLC which include diagnostic assessment (____), individual therapy (___Initial), family counseling (_____Initial), group therapy (____Initial), couples therapy (____), parenting work (____), and play therapy(____). Please have all guardians and adult clients initial all relevant services and subcategories below.

2. **Confidentiality**
   Except as described in this agreement, we will not disclose information about you, nor the fact that you are our patient, without your written consent. The practice's formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, the practice does not routinely disclose information in such circumstances, so we will require your permission

in advance, either through your consent at the onset of our relationship (by signing the attached release of information form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting your treating therapist. (______)

3. **"Limits of Confidentiality"**
Possible Uses and Disclosures of Mental Health Records without Consent or Authorization--
There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily because of policies in this office/agency, and some required by law. If you wish to receive mental health services from a therapist in this practice, you must sign the attached form indicating that you understand and accept the policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together. The practice or treating therapist may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

Emergency: If you are involved in a life-threatening emergency and we cannot ask your permission, we will share information if we believe you are in danger. (______)

Child Abuse Reporting: If we have reason to suspect that a child is abused or neglected, we are required by DC law to report the matter immediately to the Department of Social Services. (______)

Adult Abuse Reporting: If we have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, we are required by DC law to immediately make a report and provide relevant information to the DC social services. (______)

Health Oversight: DC law requires that licensed psychologists, including social workers, report misconduct by other psychologists or mental health professionals. Our policy expands upon this concept by requiring our team of professionals to report misconduct by health care providers of other professions as well. [For Counselors: DC law requires that licensed counselors report misconduct by any mental health care provider.] Therefore, if you share with a member of our team any unprofessional conduct by another mental health provider of any profession, we are required to explain to you how to make such a report. If you are yourself a health care provider, we are required by law to report to your licensing board that you are in treatment with us if we believe your condition places the public at risk. DC Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct. (______)

Court Proceedings: If you are involved in a court process and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information unless you provide written authorization or a judge issues a court order. If we receive a subpoena for records or testimony, we will notify you so you may, if you wish, file a motion to quash the subpoena. However, while awaiting the judge's decision, we may be required to place said records in a sealed envelope and provide them to the Clerk of Court. In civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, DC has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if we do an evaluation for a third party or where the evaluation is court- ordered. You will be informed in advance if this is the case. ***While it is our experience that therapist involvement in court proceedings is not helpful to the therapeutic process and jeopardizes a client's confidentiality, we do recognize that at times it is unavoidable. Court attendance requires a minimum initial appearance fee of $1000, and will be billed hourly for direct contact and preparation time thereafter***, which will be charged to the parent or guardian or responsible party, and therefore it should be discussed at the onset of treatment or upon discovery. (_______)

Serious Threat to Health or Safety: Under DC law, if we are engaged in our professional duties and you communicate to a member of our team a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and we believe you have the intent and ability to carry out that threat immediately or imminently, we are legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the

potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. Further, you agree that we may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, we may be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or law enforcement officer, whether you are a minor or an adult. (_______)

Workers Compensation: If you file a worker's compensation claim, we are required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider. (_______)

Records of Minors: DC has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records; and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Please refer to our procedures for releasing medical records to parents, as specified in How We Work With Divorcing Parents. Other circumstances may also apply, and we will discuss these in detail if we provide services to minors. Other uses and disclosures of information not covered by this notice or by the laws that apply will be made only with your written permission. (_____)

4. **Patient's Rights and Provider's Duties Right to Request Restrictions**
You have the right to request restrictions on certain uses and disclosures of protected health information ("PHI") about you. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. If you ask us to disclose information to another party, you may request that we limit the information we disclose. However, we are not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell us: 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply. You have the right to request that we not report or disclose your health information to your health insurance company if you pay for services entirely out of pocket. (_______)

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 us. Upon your request, we will send your bills to another address. You may also request that we contact you only at work, or that we do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted. (_______)

Right to an Accounting of Disclosures: 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 written request, we will discuss with you the details of the accounting process. You have the right to restrict certain disclosures of Protected Health Information to a health plan if you pay out of pocket in full for the healthcare service. You have the right to be notified if there is a breach of your unsecured PHI. You must sign an authorization form before we can release PHI for any uses and disclosures not described in your Privacy Notice. (_______)

Right to Inspect and Copy: In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing to Dr. Allison Sibley, PhD, LICSW, Director. If you request a copy of the information, we may charge a fee for costs of copying and mailing. Alternatively, we may deny your request to inspect and copy in some circumstances. Further, we may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding. (______)

Right to Amend: If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing, and submitted to us. In addition, you must provide a reason that supports your request. We may deny your request if you ask us to amend information that: 1) was not created by us; however, we will add your request to the information record; 2) is not part of the medical information kept by us; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete. (______)

Right to a copy of this notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. (_____)

Changes to this notice: We reserve the right to change our policies and/or to change this notice, and to make the changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. We also have copies of the current notice available on request. (______)

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to our office. You may also send a written complaint to the U.S. Department of Health and Human Services. (_______)

5. **Treatment of Minors**
We believe in providing a minor child with a private environment in which to disclose himself or herself in order to facilitate therapy. Therefore, it is important for guardians to give permission for therapists to use our professional discretion, in accordance with professional ethical standards and local, state and federal regulations, in deciding what information revealed by your child is to be shared with guardians. Regular parent consultation occurs via telephone or face-to-face conferences in which feedback is provided and specific recommendations are offered. Confidentiality for child/adolescent clients is maintained in order to enhance and promote open and honest disclosure and a therapeutic relationship with the exception of unsafe or risky behaviors warranting further intervention with parent involvement. (_______)

6. **Social Media and Electronic Communications**
Therapists in this practice utilize email and texting primarily for basic communication with parents, which might include coordinating schedules, providing brief updates, sending monthly invoices, or planning a phone session. If you choose to email, please understand that email is not completely confidential or secure. We do not use email as a means for extensive communication about clinical matters, and we request that you call (rather than email or text) your therapist for cancellations at least 48 hours before the scheduled appointment. We use social media (i.e. Yahoo groups, Facebook, professional listservs, LinkedIn) for some aspects of professional practice. In order to protect client confidentiality and to maintain the integrity and purpose of the therapist/client relationship, therapists do not "fan," "friend," "follow," or interact with clients or clients' family members through social media (i.e. Twitter, LinkedIn, Facebook, etc.). Therapists utilize texts with clients or parents for scheduling purposes or brief communications. While we do secure our voicemails, and safeguard our emails and phones through HIPAA compliant practices and password protection, we inform you that these communications are not encrypted—therefore not completely private or secure---and do ask that you do not communicate important personal or safety information through those means. (_______)

7. **Client Responsibilities**
Your appointments are reserved for you, and/or your child (if applicable). If you have to cancel your appointment, we ask you to provide at least 48 hours' notice. You will be charged for any appointments cancelled within 48 hours, unless there is an emergency. Regularly held weekly therapy slots, which are repeatedly missed and unable to be rescheduled, will also be added as a charge to your bill. (______)

8. **Financial Responsibilities**
Services are on a self-pay basis and payment is expected at the time services are rendered, either by check or credit card charge. If you plan to file for Out-of-Network reimbursement through your insurance company, a receipt will be provided at the end of the month. Please consult our Explanation of Fees sheet for details about specifics charges and services. ***It is our policy to require credit card information on all accounts and to charge credit cards at the time of service and thereafter we will use the credit card on file if your account is delinquent for more than 30 days.*** If you do not wish to pay by credit card, you must bring a check each session. You will receive a monthly electronic receipt via a HIPAA compliant password protected email for insurance reimbursement. If you or your child is treated by more than one therapist (i.e. group and individual therapy sessions), you will receive separate receipts for each therapist in order to comply with insurance and tax regulations. Please contact Dr. Allison Sibley (202.744.1086) to discuss past due accounts or special payment needs. Fees are typically raised on an annual basis in January. (______)

9. **Training and Professionalism**
As practicing psychotherapists, all therapists are required to participate in continuing education. This is not only to maintain licenses, but also to continue growing as therapists and for the benefit of our clients. In addition to continuing education, we are committed to seeking consultation and supervision as needed. At times, clinicians seek and provide advanced training and education. All identifying information will be disguised if used for training or education purposes. Confidentiality standards are maintained through this process as well. We subscribe to the Code of Ethics and Licensing Board Regulations for social work, counseling, and play therapy. Resume and Training Summary are available upon request. If a conflict occurs in the course of the counseling relationship, we prefer to discuss this with you as part of the counseling process. If there is a complaint or you are dissatisfied, we would request that you discuss the issue with the therapist first. If we are not able to resolve the concerns, you have the right to contact the licensing agency (Department of Health—Health Care Licensing & Customer Service Division, Board of Social Work 1-888-204-6205). (______)

10. **Play Therapy/Art Therapy Services**
We use play therapy and art therapy as adjunctive or primary treatment modalities for children. Our staff includes a credentialed Registered Play Therapist [RPT] and Registered Play Therapist Supervisor [RPT- S], which means that we have specialized training in working with children especially using expressive therapies. You have the right to understand this treatment approach and its usefulness. Handouts are available to explain the therapeutic benefits of play therapy. These techniques allow therapists to work with your child in a way that enhances his/her ability to express and communicate in an age-appropriate manner. With your permission, pictures, audiotapes or videotapes may be taken of therapy sessions, artwork, sand-trays, or play therapy sessions for the purpose of documenting treatment, treatment review and for professional training purposes. These items and photo-representations are treated as confidential. All evidence of identity will be removed if used for training purposes. If you have concerns about this aspect, please discuss them with your therapist. Although they are not part of the medical record, the items will be stored confidentially to protect their quality and content. (______)

11. **Group Therapy**
All therapists are trained and supervised to provide group therapy using an integrative group psychotherapy model. This model includes elements of cognitive behavioral treatment (i.e. “talk therapy”) and expressive therapies (i.e. play therapy, game therapy, art therapy). This model is bolstered by an understanding of the developmental needs and goals of children and parents, and treatment is enhanced by regular individual sessions and parent meetings. (______)

12. **Crisis Services**
If you are having a crisis or need to reach your therapist, you can call their contact number or alternatively, Dr. Allison Sibley by calling 202.744.1086. If you need one of us to get back to you immediately, please specify so in your message. Messages are checked periodically throughout business days. Please note that there are times when your therapist will not be available. If this is a concern for you, please discuss this with her/him. You may benefit from a therapist who is more available. If you are having an emergency, please call 911. (______)

13. **Termination of Therapy**
It is a policy of this practice to support all endings of therapy no matter what the reason. Attending therapy is a commitment of time and energy. We believe the commitment is worth it and have seen many clients and families benefit from their efforts. Growth is a process that occurs over time and often step by step. It is our experience that terminating therapy is most successful by discussing and planning together for the ending. If you decide to end or pause therapy for any reason, please discuss those wishes with us so that we can support a good ending for you, your child, and/or your family. If we have not received proper communication from you/your family within 60 days, we will consider that you wish to end this phase of treatment and close your medical record. (______)

14. **Electronic Medical Records**
As of September 1, 2015, we transitioned to electronic medical records for all patients. This system is encrypted, secured, and HIPAA compliant. All services will be charged and paid on the day of service by check or credit card. Monthly statements will be issued to you for your records or for insurance reimbursement. (______)

By signing this section of the form you have read, understand, and agree to the aforementioned terms.

____
Client Name (Please Print)

____
Client Signature: Date:

____
Both Responsible Parties: Date:

I have confirmed with the child/adolescent and his or her parent(s) that they have no further questions and wish to commence with treatment.

____
Psychotherapist: Date:

By signing this section of the form, you are indicating that you have discussed your presenting problem, diagnosis (if applicable), therapy plan, treatment options/risks with your therapist and that you agree with the plan to move forward.

____
Client Signature: Date:

____
Both Responsible Parties: Date:

I have confirmed with the child/adolescent and his or her parent(s) that they have no further questions and wish to continue with treatment.

____
Psychotherapist: Date: