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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, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

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

I have received a copy of the Notice of Psychiatrist's Policies and Practices to Protect the Privacy of Health Information (HIPAA).

_____Client's Signature (Parent/Guardian if under 18)

_____Date

Consent for Treatment.

I voluntarily request Dr. Lucy Barts, M.D., to treat my condition, which may include but is not limited to mood disorders, anxiety disorders, personality disorders, psychotic disorders, attention deficit disorder and learning difficulties.

I understand the treatment is a specialized service and I must have a primary care doctor (PCP) for standard preventative and medical care (immunizations, complete physical exams, EKG, PAP smears, etc.). I agree to see my PCP for regular monitoring and preventative measures at least on a yearly basis. I understand there are general guidelines for such treatment and agree to discuss with my PCP on a regular basis the need for these preventative measures. I understand it is not the responsibility of Dr. Barts to arrange for such treatment, but agree to comply if either Dr. Barts or my PCP suggests such treatment.

Dr. Barts may employ natural and pharmaceutical treatments that may not fall under the strict guidelines of conventional medicine as defined by those health care methods of diagnosis, treatment or interventions offered by most licensed physicians as generally accepted routine practice and some of the treatments may be considered complementary, integrative, alternative, non-conventional or non-standard. You have the right as a patient to be informed of your condition and the recommended conventional, integrative, complementary, alternative, non-conventional or non-standard procedure to be used so you may make an informed decision whether or not to undergo the treatment after learning of the risks involved.

I understand Dr. Barts will direct treatment based on signs, symptoms, neuropsychological assessments and laboratory results where clinically appropriate. I understand it is not always possible to give a definitive diagnosis. I understand, consent and authorize that I may be treated conventionally and/or with alternative, herbal and nutritional therapies, off-label use of pharmaceuticals, behavior modification, individual and group therapies and coaching. I realize just as there may be risks in continuing my present condition with or without conventional medical treatments and procedures, there are also risks and hazards related to the performance of the alternative, integrative, complementary, non-conventional or non-standard procedures and treatments planned for me. I agree to ask about risks associated with any treatments and discuss this with Dr. Barts before any treatment is begun and will not agree to treatment unless the risks have been explained to me to my satisfaction and I understand those risks.

I agree to comply with requests for ongoing testing to assure proper monitoring of treatments. I agree to immediately report to Dr. Barts any adverse reaction or problem related to treatment. I understand that along with the benefits of any medical treatment or therapies, there are potential risks and complications both of treatment and not being treated. This may include worsening of current symptoms, development of new symptoms and undesirable interactions between treatments, including conventional, complementary, integrative, alternative or non-standard treatments. I agree that I have received sufficient information regarding these risks and benefits, have had all my questions sufficiently answered and agree to proceed with treatment and to comply with recommended dosages. I have not been promised or guaranteed any specific benefit of the administration of therapies or treatment and no warranty or guarantee has been made regarding results of treatment.

I have been given an opportunity to ask questions about my condition, conventional treatment, integrative and complementary treatment, alternative forms of treatment, risks of treatment, risks of non-treatment, procedures to be used and the risks and hazards involved, and I believe I have sufficient information to give informed consent. I certify this form has been fully explained to me, I have read it or had it read to me and I fully understand its contents. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits.

I have been informed that Dr. Barts does not accept medical insurance and that many insurance companies may not pay for some therapies, and I agree to be responsible for all laboratory, pharmacy, therapies, administrative and office visit charges with the full understanding that I may not be reimbursed by my insurance company. Dr. Barts is not responsible for an insurance company's payment.

*Name of Client (please print)*_____

Signature of Client _____*Date*_____