Dr. Ruthie Norman LICSW LLC
Trauma Treatment & Recovery Psychological Services

Informed Consent for Psychotherapy Form

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me.

Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1.*If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.*

2. *If a client threatens grave bodily harm or death to another person.*

3. *If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.*

4. *Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.*

5.*Suspected neglect of the parties named in items #3 and # 4.*

6. *If a court of law issues a legitimate subpoena for information stated on the subpoena.*

7. *If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.*

8.*Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.*

Treatment Consent

I acknowledge and agree to the following:

- I understand that in therapy I may do all or some of the following: gain additional skills, address specific problems, gain a better understanding of myself, resolve painful experiences, and improve cognitive functioning & emotional well-being.
- I understand that I may learn a variety of coping mechanisms, problem solving strategies and other behavioral approaches. I understand that I may also gain insight into thinking patterns and behavior by the use of cognitive-behavioral therapy.
- If I have any questions or concerns about my treatment I will communicate them to my therapist and my therapist will answer them to the best of her ability.
- I understand that various therapeutic techniques are useful tools in many cases but there is no guarantee of a specific outcome.
- I agree to actively engage in my treatment by attending scheduled appointments.
- I understand that I may terminate therapeutic services at anytime.

My signature below indicates that I have read and understand the above consent to treatment with Dr. Ruthie Norman, LICSW, under the conditions specified above. I hereby give my consent to treatment.

______________________	______________________	______________________
Parent Name	Parent Signature	Date

Client Name ______________________________________

Dr. Ruthie Norman, LICSW
1029 NORTH ROAD SUITE 24 WESTFIELD, MA 01085
Office Phone: 413-668-2282 ● Fax: 413-315-9684 ● Email: TTRPS@DrRuthieNorman.com ● Web: www.DrRuthieNorman.com

Informed Consent and Service Agreement for Child Psychotherapy

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision. However, I ask that you allow me the option of having a closing session with the child to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in securing and maintaining that trust. It is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records. It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. I will not share with you specific content that child has disclosed to me **without your child's consent.**
If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, **I will inform you.**

Although my responsibility to your child may require my involvement in conflicts between parents, my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither parent will attempt to gain advantage in any legal proceeding between the two parents from my involvement with your children. In any such proceedings, neither of parents will ask me to testify in court, whether in person, or by affidavit. Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. I am not an evaluator of custody or visitation time. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision.

PARENT INVOLVEMENT

It is important that the parent is involved in the treatment of said child; parental involvement is required for your child's treatment with Dr. Ruthie Norman, LICSW. It is imperative that at least monthly, you, the parent or guardian, are available by phone or appointment at my office for a consultation regarding your child's treatment.. As your child's therapist, I will make every effort to communicate with you at least monthly regarding your child's progress.

CONSENT TO TREATMENT FOR MINOR

I authorize and request that Dr.Ruthie Norman, LICSW, LLC provide psycho-therapeutic services determined to be clinically appropriate for my child. I understand that the primary goal of these services is to help my child be at his/her most successful emotionally, socially and academically. **I hereby represent that I have the legal authority to obtain treatment and counseling for the minor child for whom I am requesting treatment.** I am a biological parent or legal guardian. If group home or foster family settings, I am designated to authorize treatment. If divorced, I am the primary custodial parent and can secure treatment without the authorization of the other parent. I have read and understand the terms stated in this form. I fully understand the scope of the services, policy, and treatment. I agree to abide by the terms stated throughout the course of our therapeutic relationship.

STATEMENT OF INFORMED CONSENT

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Child's Name____**Date of Birth:** _________________________________

Parent/guardian Name: ____________________________________**Signature:**_____________________________________

Parent/guardian Name: ____________________________________**Signature:**_____________________________________

Date:_________________________________

Dr. Ruthie Norman LICSW LLC

Trauma Treatment & Recovery Psychological Services

ACKNOWLEDGEMENT OF NOTIFICATIONS

I acknowledge receipt of the following documents provided to me by Dr. Ruthie Norman LICSW LLC: **NOTICE OF PRIVACY PRACTICES, INFORMED CONSENT FOR PSYCHOTHERAPY & DISCLOSURE STATEMENT AND AGREEMENT FOR SERVICES CONTRACT FORM.** I understand that these documents are available on Dr. Ruthie Norman''s website but that I may also at anytime request a hard copy if I am unable to access it.

Client name:____________________________________ Parent name:____________________________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of **HIPAA Notice of Privacy Practices.** My signature below also confirms that this document has been explained in a manner that is clear to me and that all questions I had regarding this document, were answered to my satisfaction.

____________________________________ ____________________________________

Parent Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF INFORMED CONSENT FOR PSYCHOTHERAPY

I consent to treatment provided by Dr.Ruthie Norman, LICSW who is a Licensed Independent Clinical Social Worker (LICSW) in the state of Massachusetts, license #117743. If I have a concern or complaint regarding my treatment, I will talk with her about it. If I believe that she has been unwilling to listen and respond, or that she has behaved unethically, I can contact The Board of Registration of Social Workers which oversees licensing. By signing below, I am consenting to treatment provided by Dr.Ruthie Norman, LICSW and I am acknowledging that I have received a copy of the document: ***Informed Consent for Psychotherapy***. My signature below also confirms that this document has been explained in a manner that is clear to me and that all questions I had regarding this document, were answered to my satisfaction.

____________________________________ ____________________________________

Parent Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF DISCLOSURE STATEMENT AND AGREEMENT FOR SERVICES CONTRACT

My signature below authorizes Dr.Ruthie Norman, LICSW, LLC to provide psycho-therapeutic services determined to be clinically appropriate for myself, the client. I have read and understand the terms stated in this disclosure and contract. I fully understand the scope of the services and confirm that this contract has been explained in a manner that is clear to me and that all questions I had regarding this document, were answered to my satisfaction.I agree to abide by the terms outlined and stated in this contract and throughout the course of our therapeutic relationship.

____________________________________ ____________________________________

Parent Signature Date

Dr. Ruthie Norman LICSW LLC

Trauma Treatment & Recovery Psychological Services

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

Make sure that protected health information ("PHI") that identifies you is kept private.
Give you this notice of my legal duties and privacy practices with respect to health information.
Follow the terms of the notice that is currently in effect. I can change the terms of this Notice, and such changes will apply to all information I have about you. If changes occur you will be notified and the new notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.
For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery

request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III.CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:
1.Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For my use in treating you.
b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For my use in defending myself in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
e. Required by law and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2.Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3.Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV.CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:
1.When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2.For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3.For health oversight activities, including audits and investigations.
4.For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5.For law enforcement purposes, including reporting crimes occurring on my premises.
6.To coroners or medical examiners, when such individuals are performing duties authorized by law.
7.For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8.Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9.For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10.Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V.CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.
1.Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
VI.YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1.The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2.The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3.The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4.The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5.The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6.The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7.The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

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My signature below also confirms that this document has been explained in a manner that is clear to me and that all questions I had regarding this document, were answered to my satisfaction.

____________________________ ____________________________
Parent/Guardian Name Parent/Guardian Signature

____________________________ ____________________________
Client Name Client Signature (If applicable)

____
Date

DR. RUTHIE NORMAN LICSW LLC

1029 NORTH ROAD SUITE 24 WESTFIELD, MA 01085

Office Phone: 413-668-2282 ● Fax: 413-315-9684 ● Email: TTRPS@DrRuthieNorman.com ● Web: www.DrRuthieNorman.com

DISCLOSURE STATEMENT & AGREEMENT FOR SERVICES CONTRACT

Welcome to my practice! You are taking a valuable step towards mental health healing. The following information answers some important and frequently asked questions concerning my practice. Please read this form carefully and let me know if you have any questions or need more information about policies or treatment. This document will serve as your agreement for treatment. When you sign this document, it will represent an agreement between us.

Dr. Ruthie Norman, LICSW: I am a Clinical Social worker in private practice. I hold a masters degree and doctoral degree in social work and have been a Licensed Independent Clinical Social Worker in Massachusetts since 2013. (License # 117743) I adhere to the National Association of Social Workers Code of Ethics.
Grievance Procedure: If at any time you are dissatisfied with your treatment, please discuss your concerns with me directly so we can work together to resolve them. If, after doing so, you would like a referral to a different therapist, I would be happy to assist you. If you ever have serious concerns that are not resolved successfully with me directly, you may call the Massachusetts Board of Clinical Social Workers.

CONTACT

Please feel free to reach me through phone at 413-668-2282.
I am also available by email: TTRPS@DRRUTHIENORMAN.COM, or through web services at DRRUTHIENORMAN.COM. When I am not available, my telephone is answered by an answering service voice mail that I do monitor frequently. All messages will be returned promptly if urgent. If an emergency, please state this clearly in the voicemail.I will make every effort to return your call in a timely manner. If you are unable to reach me or feel that you can't wait for a return call, contact your local crisis center at 413-733-6661, or dial 911. Additionally, if you feel you require immediate attention and can safely get to your local emergency room, ask for mental health crisis services.

THERAPEUTIC SERVICES

My approach to therapy is goal-directed, which means your counseling sessions will be designed to help you overcome your current challenges and reach your goals. I may use many different methods to treat the problems that you hope to address. However, psychotherapy is not like a medical doctor visit. It calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Change and growth involve taking risks. In deciding if now is the right time for you to pursue personal counseling, you will want to be aware of both the risks and benefits of therapy. Being aware of our true feelings can sometimes, for a time, result in uncomfortable levels of sadness, fear, anger, and related emotions. While being supported in counseling, you may choose to recall and to think in some detail about difficult moments from your past. Such remembering can be emotionally difficult. Also, clients in therapy can have increased problems with people important to them. People we care about may not be comfortable with new choices we make. The phrase that "sometimes things have to get worse before they get better" can be true in therapy. This can leave a client feeling that problems have actually increased after beginning treatment. Most of these risks are to be expected when people are making any important changes, particularly when we are pursuing healing and growth in critical areas of our lives. A final risk is simply that you would spend your time and money in counseling and not see improvement. The best protection against this risk is to talk directly with me if therapy is, in any way, not meeting your goals. Such directness is welcomed by me and may be critical for you to get the benefits you want from our time together.

While you consider these risks, you should also know that the benefits of therapy have been documented in numerous carefully designed research studies. However, therapy has also been shown to have benefits for people who go through it. The benefits of reaching your goals can lead to improved relationships, solved problems and stable mental health. But there are no guarantees of what you will experience.Therapy can help people better manage difficult feelings such as sadness or anger. Fearful and anxious feelings can be significantly lessened and

better controlled. Being in counseling also gives you the chance to talk things out fully in a setting that is confidential and respectful. Clients in therapy may grow in many directions. You can gain greater clarity about your personal goals and values; you may receive more satisfaction from social and family relationships; you may find yourself more able to simply enjoy being alive. I don't take on clients I don't think I can help. Therefore, I enter our therapeutic relationship with optimism about your progress.

Our first few sessions will involve an evaluation of your needs. By the end of this period, I will be able to offer you some first impressions and should you choose to continue with therapy we will develop a treatment plan together. Successful therapy involves a large commitment of your time so you should be very careful about the therapist you select. Whenever you have questions or concerns we will discuss them whenever they arise. If you have persistent doubts, I will be happy to make a referral with other mental health professional for a second opinion.

Most therapy relationships end when the client's goals are achieved. However, there could be circumstances in which you or I will end the relationship regardless of the other's preferences. You are free to end therapy at any time for any reason. If your plan is to end before meeting your goals, a final session can be scheduled to review your progress and discuss any referrals that might be beneficial to you. I reserve the right to end our therapeutic relationship if any policies and procedures stated in this agreement are not abided by.

ATTENDANCE POLICY

Once psychotherapy has begun we will initially meet weekly for a 50 minute session, although sometimes sessions will be longer or more frequent. Once an appointment time has been agreed upon and scheduled, you will be expected to attend and responsible for payment of it unless you cancel with at least 24 hrs notice [unless we both agree that you were unable to attend due to circumstances beyond your control]. If you do not cancel an appointment with at least 24 hours notice, or do not cancel your appointment at all, it is considered a no show. No shows may be subject to a $25.00 missed appointment fee if applicable. In such event, an invoice will be mailed to you and payment is due in a timely manner. In order to receive the greatest therapeutic benefit, it is important that you attend your appointments as scheduled. If you are late for your appointment, you will have the remaining time allotted for the meeting unless I am otherwise able to extend our meeting past the original appointment time. If you need to reschedule, please contact me as soon as possible so that I can attempt to find another time to reschedule the appointment but cannot make any guarantees. Please use the office phone line or e-mail to cancel sessions. Chronic attendance concerns or 3 or more no shows of scheduled appointments may result in a closing of your case at this office.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment 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 the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very 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. 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 clear confusion, I will be willing to call the company on your behalf.

FEES AND PAYMENT

Your co-payment is due at the time of service unless other arrangements are made in advance (or full payment, if insurance is not used or your deductible is not satisfied). If you are not utilizing health insurance benefits to pay for services, my hourly fee is $140. 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 which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. Frequent or extended telephone calls and reports or letters are billed at my usual therapy rate, with a 15 minute minimum charge. *Phone calls and letters/reports are not billable to insurance.* In proven circumstances of extreme financial hardship, I may be willing to negotiate a fee

adjustment or create a payment installment plan. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, the option of using legal means to secure the payment may become necessary. This may involve a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

LEGAL/COURT INVOLVEMENT

If you enter into treatment with me, you are agreeing not to involve me in legal/court proceedings or to attempt to obtain records of treatment for legal proceedings. This prevents misuse of your treatment for legal objectives. My goal is to support you in achieving therapy goals, not to address legal issues that require an adversarial approach. If you are involved in or anticipate being involved in legal or court proceedings, please notify me as soon as possible. It is important for me to understand how, if at all, your legal involvement might affect our work together. It is important for you to recognize that treatment is not an appropriate way to obtain evaluative results. If you need a formal psychological evaluation, I will be happy to assist you to find a provider who offers this service.

If you become involved in legal proceedings that require my participation, Dr. Ruthie Norman, LICSW, LLC involvement in court or legal matters will be strictly limited to that which will benefit my client. This means, among other things, that you are to not attempt to gain advantage in any legal proceeding from my treatment. In particular, you agree that in any such proceedings, Dr. Ruthie Norman, LICSW, LLC, will not be asked to testify in court, whether in person, or by affidavit.

Note that such agreement may not prevent a judge from requiring my testimony, despite Dr.Ruthie Norman, LICSW, LLC attempts to prevent such an event. If I am required to testify, I am ethically bound not to give opinions about parent’s custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, Dr. Ruthie Norman, LICSW, LLC will provide information as needed (if appropriate releases are signed or a court order is provided), but will not make any recommendation about the final decision. Furthermore, if I am demanded to appear in court, the party responsible for my participation agrees to pay for court preparations and agrees to pay my current rate of $140.00 per hour for time spent traveling, preparing reports, testifying, attendance and any other case-related costs.

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. I am also willing to conduct a review meeting without charge.

CONFIDENTIALITY

Confidentiality is maintained as a part of the counseling process in accordance with the ethical standards set forth by my profession and applicable law. All communication between client and therapist is kept strictly private and confidential. No one other than your therapist may have access to this information without your WRITTEN permission, with the exception of the following legal limitations: (1)If you are in danger of doing immediate harm to yourself or to others, your therapist may have to contact other individuals or agencies to assist in protecting your safety and the safety of others. (2)In certain criminal or civil matters, our records and/or professional testimony may be subpoenaed at the request of the court or attorney. Such events are rare, but if they occur you would be notified by the clinician. (3)If the therapist suspects a child, senior citizen, or disabled person is at risk for abuse or neglect, the therapist is bound by state law to report this to the state agency responsible for investigating allegations of abuse. In such circumstances, therapists will work with the person served to coordinate appropriate action and intervention.

Another exception is that I may occasionally need to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the

information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

ELECTRONIC SIGNATURE AUTHORIZATION

Electronic signatures are a method of reducing paperwork and streamlining the collection of information. The purpose of this consent is to ensure that you are fully aware of your rights and responsibilities of agreeing to receive and sign documents electronically. This Agreement governs the rights, duties, and responsibilities of "Client" in the use of an electronic (written or verbal) signature with Dr Ruthie Norman, LICSW, LLC. You will be given sufficient opportunity to review any document prior to electronically signing the document. You have the right to have any document provided in paper or non-electronic form. A paper copy of any electronically signed document can be provided upon request at no charge. You have the right to withdraw or change your consent to sign electronic documents with electronic signature at any time. You have a choice. You do not have to participate in electronic signing of documents. By signing this consent form, Client is providing consent to the use of electronic and verbal signatures to establish Client's identity and sign electronic documents and forms associated with the provision of treatment by Dr Ruthie Norman, LICSW, LLC. Client further agrees that, for the purposes of authorizing and authenticating electronic health records, Client's electronic signature or verbal approval has the full force and effect of a signature affixed by hand to a paper document. I accept the use of electronic and verbal signatures as a valid form of my written signature for documentation associated with my treatment.

___________I do **NOT** accept the use of electronic and verbal signatures as a valid form of my written signature for documentation associated with my treatment. ***(Initial if applicable)***

EMAIL AND TEXT (SMS) MESSAGING INFORMED CONSENT

In order to communicate with you by email or text message, It's important to make sure you are aware of the confidentiality and other issues that arise when we communicate this way and to document that you are aware of these and agree to them. I understand that all e-mail messages are sent over the Internet and are not encrypted, are not secure, and may be read by others. I understand that my email communications with my therapist will NOT be encrypted and, therefore, my therapist can NOT guarantee the confidentiality and security of any information I send to her or that she sends to me via email. I understand that SMS messages are even less secure than e-mail, and the same conditions apply. I understand that for this reason my therapist has advised me not to send sensitive information via e- mail or SMS message. I hereby give permission for my therapist to reply to my messages via e-mail and text messaging. I agree that Dr. Ruthie Norman, LICSW, LLC shall not be liable for any breach of confidentiality that may result from this use of e-mail via the Internet/ SMS messaging.

___________I do **NOT** give permission for my therapist to reply to my messages via e-mail and text messaging. ***(Initial if applicable)***

INFORMED CONSENT TO TREATMENT

I authorize for Dr.Ruthie Norman, LICSW, LLC to provide psycho-therapeutic services determined to be clinically appropriate for myself, the client. I understand Psychotherapy has both benefits and risks. It requires an investment of my time and energy in order to make the process of therapy most successful. Occasionally individuals may go through periods in therapy which result in emotional discomfort, changes in relationships or temporary worsening of their symptoms. This should subside as the work progresses. I understand I retain the right to request changes in treatment or to refuse treatment at any time. I have read and understand the terms stated in this therapy contract form. I fully understand the scope of the services, policy, and treatment. I agree to abide by the terms stated throughout the course of our therapeutic relationship.

DR. RUTHIE NORMAN LICSW LLC

1029 NORTH ROAD SUITE 24 WESTFIELD, MA 01085

Office Phone: 413-668-2282 ● Fax: 413-315-9684 ● Email: TTRPS@DrRuthieNorman.com ● Web: www.DrRuthieNorman.com

Client Affidavit

I confirm that each of these sections in the Disclosure Statement & Agreement for Services Therapy Contract have been explained in a manner that is clear to me and that all questions I had regarding this contract, were answered to my satisfaction. I hereby attest that I have read, understand, and agree to Dr.Ruthie Norman, LICSW, LLC Disclosure Statement & Agreement for Services Therapy Contract.

Disclosure Statement & Agreement Contract Document

Contract Sections	
Contact	Consent to treatment
Therapeutic services	Notice of privacy practices
Attendance policy	Consent to treatment
Insurance reimbursement	Electronic Signature
Fees & payments	Email & Text (SMS) Messaging
Court or legal involvement	Acknowledgment of Notifications
Confidentiality	

____________ ***I do NOT agree to the following section(s)***

(Initials)

____

My signature below authorizes Dr.Ruthie Norman, LICSW, LLC to provide psycho-therapeutic services determined to be clinically appropriate for myself, the client. I have read and understand the terms stated in this therapy contract form. I fully understand the scope of the services and confirm that this contract has been explained in a manner that is clear to me and that all questions I had regarding this document, were answered to my satisfaction.I agree to abide by the terms outlined and stated in this contract and throughout the course of our therapeutic relationship.

____________________ ____________________

Client Name Client D.O.B

____________________ ____________________ __________

Parent/Guardian Name Parent/Guardian Signature Date