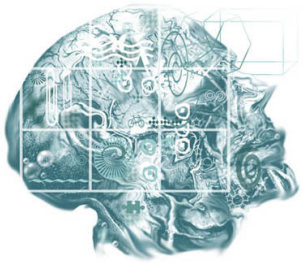

Confidentiality & Contact Form

Communication between a client and Dr. Antoine Spiteri is privileged and confidential. This means that Dr. Spiteri cannot discuss a case, orally or in writing, without the written permission of the patient.

In some instances, I may gather data to be used for case studies or as part of other statistical analyses in scientific publications. In such instances the information is not used in conjunction with client's name and confidentiality is maintained. If you do NOT wish to take part in research that may advance science, please tick here □

Some state laws specify there being special circumstances when a mental health professional may be required to break confidentiality. These circumstances include when a person is a threat to themselves (such as being suicidal). Being a threat to others (such as homicidal) is another instance where confidentiality can be broken. A third situation where state laws may require breaking confidentiality is when someone is suspected of being abusive to others, such as children, the disabled, or elderly. A fourth possibility is if court requires it. This typically happens when you are involved in a lawsuit.

It is also understood that Dr. Spiteri may seek peer consultation of my case. This is a common professional activity that is permitted under the laws governing therapist/patient confidentiality. Such consultation does not require specific consent from the patient. My confidentiality is maintained between Dr. Spiteri and from whomever he may seek consultation.

If consultation is sought in my case, it is intended to serve my best interest. Reasonable efforts will be made, when clinically appropriate, to discuss and/or resolve these issues of before such a release of information takes place. The appropriateness of such discussions will be within the sole discretion of Dr. Spiteri. Your signature below indicates that you have read and understood these statements.

_____ _____

Signature (Parent or guardian for a minor) Date

Client's Name:_____ **DOB:**_____

Street address (no PO boxes please)_____

City:_____ _____**Zip:**_____

Phones ok to call: (H)_____**(W)**_____**Cell:**_____

Payment of €250 **must be received by no later than 24 hours prior to consultation by bank transfer to Bank Of Valletta, Triq Manwel Dimech, St Julians, Malta SLM 1051, into account number 400 16115091. For international money transwers please allow an additional 4 business days for your transfer to register into the receiving account. SWIFT VALLMTMTXXX, IBAN MT17VALL22013000000040016115091**

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This form is for me to check you are ok for us to work together.

1. CONFIDENTIALITY

You understand that I won't tell other people what you tell me. It will stay private. Except: A. if I am worried about your safety. B. if I am worried about someone else's safety.

C. With your permission, I might say some of what you tell me to other people in the team (e.g. psychiatrists, speech and language therapist), if they need help to work with you, or if I need their help to work with you.

You understand and agree with this

2. RECORD KEEPING & SHARING INFORMATION

I might write notes when you talk. I will then put these notes on a secure (safe) database. A database is like a folder on a computer with your name on it. It is private and safe (encrypted and password protected), so only I can see it.

You agree with this

It may be useful as part of your care and/or your child's care to communicate with other professionals helping you. Please indicate, by ticking the relevant boxes, who you give me permission to communicate with: Yes No N/A

Other professionals (e.g. psychiatrist, speech and language therapist) Yes No N/A

School (if relevant) Yes No N/A

Other professionals working with me Yes No N/A

Other organisations (e.g. Inspire, Hand in Hand) Yes No N/A

Other professionals not mentioned above Yes No N/A

3. **OPTIONS**

I am a personal consultant. I will try to help you with your problems by having different types of meetings. I usually ask lots of questions. I might just meet you once or twice but usually I work with people for months or sometimes more than a year.

These are the types of meetings that we might have:

- 1 TO 1 CONSULTATIONS: I will meet with you alone to talk about the problems.

- PSYCHOMETRIC ASSESSMENT: I will ask you to do things like puzzles and drawings to understand more about the problems you may be facing.

- BEHAVIOURALASSESSMENT:I will meet you and your family to see if there are any problems we can help with.

- NETWORK MEETINGS: I will meet you with your family and people who work with you to talk about how we can help.

You agree that I can offer the treatment option/s ticked above.

4. **CONTACT**
I may need to contact you from time to time (e.g. to set up appointments).

You are agreeing for me to communicate with you via:

a) This email address: _____

b) This telephone number: _____

I also understand that my and/or my child's name and contact details will be shared with personal assistants and my clinics for scheduling purposes

5. TELECONSULTATIONS

TELECONSULTATIONS have been determined as an appropriate service delivery model. This form of delivery may be used as the primary means of service delivery or may be used in combination with in-person services. Once the COVID-19 measures are lifted, this may still be an option available to individuals, if they feel the need. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the consultant, that: the transmission of my information could be disrupted or distorted by technical failures. The consultant uses Zoomand Teams to provide consultation services.

I understand that I am responsible for *

	Yes	No	N/A
providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions	☐	☐	☐
the information security on my computer	☐	☐	☐
arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session	☐	☐	☐
That payments are all pre-paid via Revolut, BOV mobile pay or Via Paypal upon scheduling the appointment	☐	☐	☐

6. PAYMENT (FOR ONLINE SESSIONS)

Kindly note that payment of €250 needs to be pre-paid via bank transfer as indicated on page 1

You are indicating that you are aware of the payment method

7. CANCELLATIONS AND NO SHOWS

Please note that for appointments cancelled less than 48 hours notice, there will be a €50 charge.

For appointments cancelled less than 24 hours notice and for no shows (i.e. where people fail to show up or cancel), there will be a €50 charge.

Please can you sign here:
Client's name: _____Client's signature: _____
Date: _____

Consultant name: Dr Anthony Spiteri signature: _____

Biographical Information

Client's name:_____

Why are you seeking assessment for yourself (or for your child)?:

Current medication taken by the client:

Past or present in-patient or out-patient therapy for the client:

History of suicidal/homicidal issues by client or in the family:

Alcohol or drug use by the client:

For minor children: Joint custody Solo custody Legal Custody