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Your Right to Privacy, My Duty of Confidentiality, and the Psychotherapist-Patient Privilege

Your Right to Privacy; My Duty of Confidentiality

You have a right to privacy concerning your medical information, which includes information you share with me and the work that I do with you. The concept of medical information also includes your name, address, e-mail address, telephone number, and social security number.

By law, I have a legal duty to keep your medical information reasonably safe and secure. In general, what you share with me during our sessions is confidential, meaning I cannot share this information with third parties without your written authorization. Especially for the permitted exceptions to confidentiality, my preference, if at all possible, is to only disclose your medical information with your written authorization.

However, California law mandates or permits certain disclosures of your medical information. A mandated disclosure is one the law requires me to make, and a permitted disclosure is one the law permits me to make.

Mandated or Required Disclosures

Although you have a right to privacy concerning your medical information, I am mandated by law to report certain information in certain situations. There are numerous mandated exceptions to confidentiality, but some of the more common ones include the following:

1. If you disclose information to me that causes me to suspect that a child has been abused physically, abused sexually, exploited sexually, neglected, or endangered, I must report that information to Child Protective Services or law enforcement.

2. If you disclose information that causes me to suspect that an elder[1] or a dependent adult[2] has been abused physically, abused sexually, exploited sexually, neglected, abused financially, abandoned, isolated, or abducted, I am required by law to report that information to Adult Protective Services, law enforcement, and/or other governmental entities.

3. If you communicate to me a serious threat of physical violence against a reasonably identifiable victim(s), and I believe you have a firearm or other deadly weapon, I am required to report that information to law enforcement.

[1] Under California law, an elder is defined as someone who is over the age of sixty-five and resides in California.
[2] Under California law, a dependent adult is defined as someone between the ages of 18 and 64 who has physical or mental limitations that affect his or her ability to carry out normal life activities or protect his or her rights.

4. If a court, board, commission, or administrative agency compels me to disclose your medical information, I must comply with such order.

5. If a search warrant lawfully issued to a governmental law enforcement agency compels me to disclose your medical information, I must comply with such warrant.

6. If otherwise specifically REQUIRED by law.

Permitted or Discretionary Disclosures
Although you have a right to privacy concerning your medical information, I am permitted by California law to disclose it without your written authorization in certain situations. However, my preference is to get your written authorization ahead of time.

There are many permitted exceptions to confidentiality, but some of the more common ones include the following:

1. Consulting with your physician or psychiatrist about your diagnosis and/or treatment.

2. Submitting invoices to third party payers, such as insurance companies or government programs, to get reimbursed by them for my work with you.

3. Disclosing your medical information to third parties, including law enforcement, if I believe you are dangerous to yourself or others and I reasonably believe that it is necessary to involve them in your care to prevent or lessen an imminent risk of physical harm.

4. Disclosing your medical information to entities that provide my practice with billing, claims management, or other administrative services.

5. Disclosing your medical information to governmental agencies, including law enforcement, if I reasonably believe that a child, elder, or dependent adult is being abused emotionally.

6. If otherwise specifically AUTHORIZED by law.

The Psychotherapist-Patient Privilege
Your right to privacy concerning your "medical information" is different from your right to the protection of the psychotherapist-patient privilege ("Privilege"), which generally prevents me from testifying about information communicated between us during our work.

I will assert the Privilege on your behalf during legal proceedings, and I will do so until you, or someone acting on your behalf, waives the Privilege, or a judge, or some other judicial or

administrative officer, orders me to testify or disclose medical information during a legal proceeding.

If you are involved in a legal proceeding, or become involved in one after our work has commenced, you should consult with your attorney about how your involvement in the legal proceeding may impact your right to the protection of the Privilege.

To maximize your protection under the Privilege, you should only discuss your treatment with third parties who are reasonably necessary to further your treatment, such as your spouse, parent, or other close relative.

Additionally, you should not communicate with me from electronic devices, such as computers and phones, which you do not own, such as your employer's computer or company-issued phone. Doing so may seriously jeopardize your ability to rely on the protection of the Privilege in legal proceedings later!

Acknowledgement of Receipt of *Your Right to Privacy, My Duty of Confidentiality, and the Psychotherapist-Patient Privilege*

By signing this form below, you acknowledge receipt of the document titled "Your Right to Privacy, My Duty of Confidentiality, and the Psychotherapist-Patient Privilege." This document provides you with important information about how I may use or disclose your medical information. I encourage you to read it in full and to discuss any questions you have about it with me.

"Your Right to Privacy, My Duty of Confidentiality, and the Psychotherapist-Patient Privilege" is subject to change, and if I do change this document later, I will provide you with the updated version.

_____ _____

Date Patient/Parent/Conservator/Guardian

Credit Card Authorization

Payments are required at the time of your appointment, unless other arrangements have been made in advance. If at any point in the course of therapy you are unable to pay for your session, please communicate this to KDBTT. A credit card number must be kept on file to charge for no show appointments, last minute cancellations, and all outstanding balances that remain unpaid for more than 30 days. The undersigned hereby authorized KDBTT to charge my credit card (provided below) when I do not show up for my scheduled appointment or if I cancel in less than 24 hours in advance, for the amount of any balance remaining at the end of each therapy session, and/or after a balance has been unpaid for 30 days. If payment by check is the preferred method agreed upon, the following card will only be charged if there is an outstanding balance more than 30 days after issuance of an invoice. A current credit card number must be on file at all times, regardless of your preferred method of payment. Your card will not be charged if you choose to pay by check at the time your payment is due. All paid invoices are emailed to the cardholder at the time of charge.

The credit card to remain on file is:

Please circle one: MasterCard Visa

Card Number: _____

Expiration Date: _____ Security Code: _____

Name as it appears on the card: _____

Billing address (include zip code): _____

_____

Signature of cardholder: _____

Preferred payment is (please circle one): CHECK / CREDIT CARD / CASH

All payments by cash or check must be submitted at the time of therapy, unless other arraignments have been made. The undersigned understands and agrees to be bound to such agreements as outlined in this document. Please provide your signature below. If there is more than one adult participating in therapy, both must sign below.

Signature: _____

Print Name: _____ Date: _____

Signature: _____

Print Name: _____ Date: _____

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