Client Information and Love Counseling & Consulting Policies and Procedures

Please read this form carefully so that you understand these policies and your responsibilities as well as options. Once you have read this, please ask any questions you may still have and then sign agreeing that you understand and will abide by these policies.

Purpose of this Treatment Program

You have been referred to me for treatment following a report of sexual abuse filed against you. The purpose of this treatment program is to reduce recidivism by helping you to make better choices for the future and not to repeat behaviors that hurt yourself or others. In order to do that, we will take a look at your life-experiences, your thought-processes, and discover what your strengths and areas of need are. We will find out what you enjoy, what your goals are for the future, and build upon strengths you already possess in order to reach those goals.

Limits of Confidentiality

What is discussed during treatment is confidential and without written permission, I cannot repeat it to anyone else; however, there are certain things that I cannot keep confidential. They are as follows:

1. Reasonable suspicion of physical or sexual abuse or neglect of a child, elderly, or dependent adult.
2. Threats to harm yourself.
3. Threats to harm someone else.

Treatment Description

This treatment program is tailored to your specific needs. We will work together to set goals, but there will be some things that you will be required to do as well. Treatment usually lasts several months and involves you attending one, two-hour long group therapy session each week. You will have a treatment workbook and will be expected to complete all assignments before ending treatment. I will work with your referral source and any case workers, social workers, or other therapists, as appropriate, to ensure that you are staying on-track and complying with treatment. One way that we will monitor your compliance may be through polygraph examinations. If you are scheduled for polygraphs, you will be notified ahead of time. Some people may need to be polygraphed more or less frequently, depending on their circumstances and their level of honesty.

In addition to weekly group therapy, you will have individual or family therapy sessions during the course of treatment. I will meet with the people involved in your care regularly and submit reports about your personal progress and the program's progress in general. To ensure you receive the best treatment possible, I may discuss your case, protecting your privacy by omitting your identifying information, with other professionals in the field, such as Dr. Joseph Giovannoni who supervises my work.

Appointments and Attendance

Group therapy sessions are 100-110 minutes long. Individual, couple, and family sessions are 50-55 minutes long. You are expected to attend all scheduled sessions and to arrive on time. You may be excused in rare circumstances of illness or emergency, but a doctor's note or proof/documentation of the emergency may be required. The appropriate persons will be notified of all absences. Two unexcused absences will constitute non-compliance with treatment. A third unexcused absence may result in termination of treatment services. If you know you will not be able to come for a session, please contact me as soon as you can so that we can make other arrangements.

Smoking and substance use will not be tolerated. You are expected to arrive clean and sober. If you arrive for your session under the influence, you will be dismissed, the appropriate persons will be notified, and you will be placed on non-compliance, or you may be terminated.

The polygraphist and psychosexual evaluator come from off-island for their appointments with clients in this program, so it is extremely important that you keep your appointments with them as they may not return for months.

Emergencies

Emergencies require immediate attention or care and cannot wait until your scheduled session or regular business hours. **I am not available for emergencies. If you find that you are experiencing an emergency, please call 911 or go to your nearest emergency room.** Once you leave my office, I am not responsible for your safety or welfare and I am not required to check in with you between scheduled sessions. If you are a danger to yourself or others, please call the Suicide and Crisis Center at 521-4555 or 911 or go to your nearest hospital or emergency room.

Record-Keeping

In accordance with standard guidelines, Love Counseling and Consulting will maintain your treatment records in a private, secure format and location for 7 years after the date you are last seen. Records for minors must be held for 7 years past their 18th birthday (until age 25). If you would like your records to be transferred to another provider, please contact me to make those arrangements. If you would like your records to be held for longer than the standard, please arrange for another provider or service to hold them. You have the right to access your records, with the exception of process notes (the notes made by the psychotherapist), but there may be a fee for copies of records requested.

Other Policies

Please respect others who use this office by not eating during sessions and by arriving clean and without odor. If you smoke, please do not smoke for at least 30 minutes prior to the session. Please ensure that when you come to sessions, you wear clothing that is laundered and appropriate.

Threats and intimidation will not be tolerated and may be considered grounds for immediate termination.

Cell phones can be distracting and can interfere with the therapeutic process. Please do not take calls or respond to emails or texts during the session unless there is an emergency.

If you have children who will not be a focus of the treatment session, please arrange for childcare. They may not be left unattended on or around the premises and are not permitted in the office unless the therapist has requested they attend, or if they are the focus of therapy.

Risks and Benefits

Treatment is a privilege not afforded to everyone; you have been given an opportunity to change and grow from your mistakes. Treatment does take time and your progress depends on how hard you are willing to work and how honest you are willing to be. There are no guarantees to your success because of this treatment, and some parts will be very challenging, but you will get out of it what you put in. Treatment starts out very restrictive, and having strong boundaries in place can be very difficult to accept, but it is for your benefit and for the community's benefit. You will gain more freedom and more privileges as you demonstrate to the therapist, and others involved in your care, that you are willing to comply with treatment. During treatment, you may encounter challenges and struggles that are painful. Some things are difficult to talk about, scary to admit to, or painful to recall. If you process these things with the therapist, you can heal from them and move forward with a more positive and productive lifestyle.

_____	_____	____/____/____
Client Name	Signature	Date
_____	_____	___/___/____
Parent/Guardian Name	Signature	Date

Notice of Privacy Practices

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

Privacy is a very important concern for all those who come to this office and who work here. It is also complicated, because of the many federal and state laws and our professional ethics. Because the rules are so complicated, some parts of this notice are very detailed, and you may need to re-read them or ask questions to understand them. If you have any questions, I'll be happy to help you understand our procedures and your rights.

Contents of this notice of privacy practices

A. Introduction: To our clients

This notice will tell you how we handle your medical information. It tells how we *use* this information here in this office, how we *disclose* (share) it with other health care professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. If you have any questions or want to know more about anything in this notice, please ask our compliance officer for answers or explanations.

B. What we mean by your medical information

Each time you visit us or any doctor's office, hospital, clinic, or other health care provider, information is collected about you and your physical and mental health. It may be information about your past, present, or future health or conditions, or the tests or treatment you got from us or from others, or about payment for health care. All this information is called "PHI," which stands for "protected health information" which means its privacy must be protected. This information goes into your medical or health care records in our office.

In this office, your PHI is likely to include these kinds of information:

- Your history: Things that happened to you as a child; your school and work experiences; your marriage, relationships, and other personal history.
- Your medical history of problems and treatments.
- Reasons you came for treatment: Your problems, complaints, symptoms, or needs.
- Diagnoses: These are the medical terms for your problems or symptoms.
- A treatment plan: This is a list of the treatments and other services that we think will best help you.
- Progress notes: Each time you come in, we write down some things about how you are doing, what we notice about you, and what you tell us.
- Records we get from others who treated you or evaluated you.
- Psychological test scores, school records, and other evaluations and reports.
- Information about medications you took or are taking.
- Legal matters.
- Billing and insurance information

There may also be other kinds of information that go into your health care records here.

We use PHI for many purposes. For example, we may use it here:

- To plan your care and treatment.
- To decide how well our treatments are working for you.
- When we talk with other health care professionals who are also treating you, such as your family doctor or the professional who referred you to us. When we do this, we will ask for your consent. Almost always, we will also ask

you to sign a release-of-information form, which will explain what information is to be shared and why.

- For teaching and training other health care professionals or for medical or psychological research. If we do this, your name will never be shown, and there will be no way they can find out who you are. Before we do this we will ask for your consent and ask you to sign an authorization, so that you will know what information will be shared and why.
- To show that you actually received services from us, which we billed to you or to your health insurance company.
- For public health officials trying to improve health care in this area of the country.
- To improve the way we do our job by measuring the results of our work.

When you understand what is in your record and what it is used for, you can make better decisions about what other persons or agencies should have this information, when, and why.

C. Privacy and the laws about privacy

We are required to tell you about privacy because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Omnibus Final Rule of 2013, as well as applicable Hawaii State laws. HIPAA requires us to keep your PHI private and to give you this notice about our legal duties and our privacy practices.

This form is not legal advice. It is just to educate your about your rights and our procedures. It is based on current federal and state laws and might change if those laws or court decisions change. If we change our privacy practices, they will apply to all the PHI we keep. We will obey the rules described in this notice.

D. How your protected health information (PHI) can be used and shared

Except in some special circumstances, when we use your PHI in this office or disclose it to others, we share only the *minimum necessary* PHI needed for those other people to do their jobs. The laws give you rights to know about your PHI, to know how it is used, and to have a say in how it is shared. So now we will tell you more about what we do with your information.

Mainly, we will use it here and disclose (share) your PHI for routine purposes to provide for your care, and we will explain more about these below. For other uses, we must tell you about them and ask you to sign a written Release of Information form**.** However, the HIPAA law also says that there are some uses and disclosures that don't need your consent or authorization which we will explain below in section 3. However, in most cases we will explain the PHI and who it will go to and ask you to agree to this by signing a release-of-information form.

1. Uses and disclosures with your consent

We need information about you and your condition to provide care to you. In almost all cases, we intend to use your PHI here or share it with other people or organizations to provide treatment to you, arrange for payment for our services, or some other business functions called "health care operations." You have to agree to let us use and share your PHI in the ways that are described in this Notice of Privacy Practices. To agree, we will ask you to sign a separate consent form before we begin to treat you. If you do not consent to this, we will not treat you because there is a risk of not helping you if we don't have some information.

a. The basic uses and disclosures: For treatment, payment, and health care operations

Here we will tell you more about how your information will be used for these purposes.

For treatment. We use your information to provide you with psychological treatments or services. These might include individual, family, or group therapy; psychological, educational, or vocational testing; treatment planning; or measuring the benefits of our services.

We may share your PHI with others who provide treatment to you. If you are being treated by a team, we can share some of your PHI with the team members, so that these providers will work best together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record, and so we all can decide what treatments work best for you and follow a treatment plan.

If we want to share your PHI with any other professionals outside this office, we will need your permission on a signed release-of-information form. For example, we may refer you to other professionals or consultants for services we cannot provide. When we do this, we need to tell them things about you and your conditions. Later we will get back their findings and opinions, and those will go into your records here. If you receive treatment in the future from other professionals, we can also share your PHI with them. We can do this only when you give your permission by signing a release-of-information form. This is so that you will know what information is being shared and with whom. These are some examples so that you can see how we use and disclose your PHI for treatment.

For payment. We may use your information to bill you, your insurance, or others, so we can be paid for the treatments we provide to you. We may contact your insurance company to find out exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received, and the changes we expect in your conditions. We will need to tell them about when we met, your progress, and other similar things. Insurers may also look into a few of our patient records to evaluate the completeness of our record keeping.

For health care operations. Using or disclosing your PHI for health care operations goes beyond our care and payment for services. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies, so they can study disorders and treatment and make plans for services that are needed. If we do, your name and all personal information will be removed from what we send.

b. Other uses and disclosures in health care

Appointment reminders. We may use and disclose your PHI to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work, or you prefer some other way to reach you, we usually can arrange that. Just tell us.

Treatment alternatives. We may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of help to you.

Other benefits and services. We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Research. We may use or share your PHI to do research to improve treatments—for example, comparing two treatments for the same disorder, to see which works better or faster. In all cases, your name, address, and other personal information will be removed from the information given to researchers. We will discuss this with you, and we will not use your PHI unless you give your consent on an authorization form. If the researchers need to know who you are, we will discuss the research project with you, and we will not send any information unless you sign a special release-of-information form.

Business associates. We hire other businesses to do some jobs for us. In the law, they are called our "business associates." Examples include a copy service to make copies of your health records, and a billing service to figure out, print, and mail our bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy, they have agreed in their contracts with us to safeguard your information just as we do.

2. Uses and disclosures that require your consent

If we want to use your information for any purpose besides those described above, we need your permission on a release-of-information form. If you do allow us to use or disclose your PHI, and then change your mind, you can cancel that permission in writing at any time. We will then stop using or disclosing your information for that purpose. Of course, we cannot take back any information we have used here already or disclosed to anyone with your permission.

As a Licensed Marriage and Family Therapist and Certified Substance Abuse Counselor, I maintain your privacy according to the strictest guidelines. The HIPAA rules are described below, but we will almost always discuss these with you and ask you to sign a release of information so that you are fully informed.

3. Uses and disclosures that don't require your consent or authorization

The HIPAA laws let us use and disclose some of your PHI without getting your consent or authorization in some cases. Here are some examples of when we might do this. We will almost always notify you if any of these situations occur.

a. When required by law

There are some federal, state, or local laws that require us to disclose PHI:

- We have to report suspected abuse [or neglect] of children [elders, frail/disabled persons, etc.] to a state agency.
- If you are involved in a lawsuit or legal proceeding, and we receive a subpoena, discovery request, or other lawful process, we may have to release some of your PHI. We will only do so after making reasonable attempts to tell you about the request and will suggest that you talk to your lawyer.
- We have to disclose some information to the government agencies that check on us to see that we are obeying the privacy laws, and to organizations that review our work for quality and efficiency.

b. For law enforcement purposes

We may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

c. For public health activities

We may disclose some of your PHI to agencies that investigate diseases or injuries.

d. For matters relating to deceased persons

We may disclose PHI to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.

e. For specific government functions

We may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment. We may disclose your PHI to workers' compensation and disability programs, to correctional facilities if you are an inmate, or to other government agencies for national security reasons.

f. To prevent a serious threat to health or safety

If we come to believe that there is a serious threat to your health or safety, or that of another person or the public, we can disclose some of your PHI. We will only do this to those people who can prevent the danger.

If it is an emergency, and we are unable to get your agreement, we can disclose information if we believe that it is what you would have wanted and if we believe it will help you. When we do share information in an emergency, we will tell you as soon as we can. If you don't approve, we will stop, as long as it is not against the law.

4. Uses and disclosures where you have an opportunity to object

We can share some information about you with your family and anyone else you choose, such as close friends or clergy. We will ask you which persons you want us to tell, and what information you want us to tell them about your condition or treatment. You can tell us what you want, and we will honor your wishes as long as it is not against the law.

5. An accounting of disclosures we have made

When we disclose your PHI, we will keep a record of whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures. We may charge you a reasonable fee if you request more than one accounting in any 12-month period. If the records were sent as electronic medical records, we will always record that, and there will be no charge for an accounting.

E. Your rights about your protected health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, rather than at work, to schedule or cancel an appointment. We will try our best to do as you ask, and we don't need an explanation. Sending your information in emails has some risk that these emails could be read by someone else. You may just accept the risk of using emails just for simple messages like changing appointments, and not use it for any PHI or sensitive information, or you may request communication in a more secure forma than email. We ask that you be thoughtful before you put any information in an email and not use email for anything you want kept private. By signing the separate consent form, you agree to this use of email. Please note that anything you send us electronically becomes a part of your legal record, even if we do not place it in the chart. Be mindful of this, and please do not forward us emails from third parties or others in your life. It is better to print those out and bring them in to discuss them.
2. You have the right to ask us to limit what we tell people involved in your care or with payment for your care, such as family members and friends. You can ask us face to face, and we may then ask for your written permission. We don't have to agree to your request, but if we do agree, we will honor it except when it is against the law, when there is an emergency, or when the information is necessary to treat you.
3. You have the right to prevent our sharing your PHI with your insurer or payer for its decisions about your benefits or some other uses, if you paid us directly ("out of pocket") for the treatment or other services and are not asking the insurer to pay for those services unless we are under contract with your insurer (on their panel of providers).
4. You have the right to look at the PHI we have about you, such as your medical and billing records. In some very unusual circumstances, if there is very strong evidence that reading this would cause serious harm to you or someone else, you may not be able to see all of the information.
5. You can get a copy of these records, but we may charge you a reasonable cost-based fee. If your records are in electronic form, not on paper, you can ask an electronic copy of your PHI. Generally we do not recommend that you get a copy of your records, because the copy might be seen accidentally by others. We will be happy to review the records with you or provide a summary to you, or work out any other method that satisfies you.
6. You have the right to add to (amend) your records to explain or correct anything in them. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records or to include your own written statements to correct the situation. You have to make this request in writing.
7. You have the right to a copy of this notice. If we change this notice, we will post the new one in our waiting area, and you can always request a copy from us.
8. If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, contact us. We will do our best to resolve any problems and do as you ask. You have the right to file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington, DC 20201, or by calling 202-619-0257.
9. We will not in any way limit your care here or take any actions against you if you complain or request changes.

You may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

F. If you have questions or problems

If you have any questions or problems our health information privacy policies, please contact us.
My signature below shows that I understand my rights regarding protected health information.

_____	_____	____/____/____
Signature of client or legal representative	Printed name	Date

_____	_____
Printed name of legal representative	Relationship to client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____	____/____/____
Signature of therapist	Date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Client Rights and Responsibilities

Clients have a RIGHT to:

- Treatment that is free from discrimination with respect to age, race, gender, sexual orientation, religion, disability, or social economic status.
- Be treated with dignity and respect.
- Privacy and confidentiality, to the extent permitted by law.
- Have the confidentiality of your health record maintained.
- Receive accurate information concerning diagnosis, treatment, risks, and prognosis of an illness or health condition.
- Inquire about reasonable alternatives to treatment with Love Counseling & Consulting or outside facilities.
- Obtain a second professional opinion regarding diagnosis or treatment.
- Be an active participant in decisions regarding your treatment.
- Be informed about any legal reporting requirements regarding any aspect of treatment.
- Receive a copy of your medical record upon receipt of written request.
- File a complaint against the therapist or Love Counseling & Consulting.
- Review and amend your medical record.
- Revoke your authorization to release information except to the extent that action has already been taken.

Clients have a responsibility to:

- Be honest and complete with information about one's illness/problem, to enable proper evaluation and treatment.
- Ask questions to ensure an understanding of anything related to treatment or your progress.
- Be respectful of the therapist and other providers including assessors, polygraphists, and probation officers, social workers, case managers, health personnel and other patients.
- Immediately notify therapist of any new offenses, violations of probation, dangerous situations, or inability to attend sessions.

_____	_____	____/____/____
Client Name	Signature	Date
_____	_____	___/____/___
Parent/Guardian Name	Signature	Date

Consent to Treatment

Name of client: _____ Date of birth: ____/____/____

The therapist named below and I have discussed my child's situation. I have been informed of the risks and benefits of different treatment choices. The treatment chosen includes these actions and methods:

1. Weekly group or individual therapy sessions.
2. Periodic family therapy sessions.
3. Periodic polygraph examinations (if deemed necessary)/ mental health and risk assessments.

These actions and methods are planned to move toward these goals:

1. Increasing general and sexual self-regulation
2. Developing effective coping skills.
3. Improving relationships.

Client-specific changes to make to the typical treatment program are as follows:

I have discussed these issues, had my questions answered, and believe that I understand the planned treatment and its likely consequences. Therefore, I agree to attend therapy and to play an active role in this treatment as needed. I give this therapist permission to begin this treatment, as shown by my signature below. I agree to pay for these services, regardless of any other resources that might be available.

I am this child's ❑·Parent ❑·Legal guardian ❑·Other: _____ and have the legal authority to make medical and treatment decisions on behalf of this child.

_____	_____	____/____/____
Client Name	Signature	Date
_____	_____	___/___/____
Parent/Guardian Name	Signature	Date

Consent for Electronic Communications

1. Risk of using email/texting:
   The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:
   1. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   2. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
   3. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
   4. Employers and on-line services have a right to inspect emails sent through their company systems.
   5. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
   6. Email and texts can be used as evidence in court.
   7. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.
2. Conditions for the use of email and texts:
   Therapist cannot guarantee, but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by therapist's intentional misconduct. Clients/Parents/Legal Guardians must acknowledge and consent to the following conditions:
   1. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
   2. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
   3. Email and texts may be printed and filed into the client's medical record.
   4. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
   5. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
   6. Provider is not liable for breaches of confidentiality caused by the client or any third party.
   7. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

_____	_____	_____/_____/_____
Client Name	Client Signature	Date
_____	_____	_____/_____/_____
Parent/Guardian Name	Parent/Guardian Signature	Date
_____	_____/____/_____	
Therapist's Signature	Date	

Agreement for Group Therapy

As a group member, I have rights as well as duties or responsibilities, and I understand that some of them are described in this agreement.

The purpose of this group is to provide me with the opportunity to achieve the following goals:

1. Understand my offense including what led up to it, why I did it, and how to prevent myself from doing it again.
2. Give and receive support from others who are in treatment for similar situations.
3. Comply with treatment standards for individuals who have engaged in harmful sexual behaviors.

I agree to work in this group. This means openly talking about my thoughts and feelings, honestly reporting my behaviors, keeping my promises, offering helpful feedback (being clear and direct about my reactions to others), and listening as fully and carefully as I can to other members' reactions to me. I have had this process explained to me and understand that it is the core process of group therapy.

I will attend all meetings of this group for the full time period, even if I do not always feel like it. If I cannot attend, I will tell the group a week in advance (at the beginning of that meeting), or, if it is an emergency, call the therapist, and if applicable, my probation officer or social worker, as soon as I know I cannot attend. If I decide not to continue or am unable to continue with the group, I will discuss my reasons with the group and its leaders/probation officer, and I will attend two sessions after the date of the discussion.

I will not socialize outside the group with any of its members or attendees. This is needed so that everyone will be equals in the group. If I happen to meet a member outside, I will tell the group at our next meeting. I promise not to socialize with members for at least 6 months after the group terminates or I withdraw.

I will also not become a "friend," "follower," or "contact" with any of the other group members on social media for at least 6 months after the group terminates. I also promise to refrain from looking up other members on social media, since this can dilute the value of what we share and disclose to one another in the group. If I fail to keep this commitment, I will discuss it with the therapist so that we can explore how this may affect the group dynamics. I will also notify the therapist if another group member makes contact with me outside the group.

I understand that this group experience is not a replacement for individual therapy. If issues arise for me that are not suitable for the group's process, I may benefit from individual therapy sessions, for which I may have to pay separately from the cost of the group therapy. I will discuss this with the therapist.

I understand that the therapist is required by law to report any suspected child or elder abuse, or credible threats of harm to myself or another person, to the proper authorities and take actions to prevent harm.

With full understanding of the need for confidentiality (respecting and supporting the privacy of what all members share with the group), I accept these rules:

1. I promise to tell no one outside the group the names of the group members, or in any other way allow someone not in the group to learn their identities.
2. I will not bring friends, relatives, significant others, etc. to sessions.
3. We will not permit any kind of recordings (audio or video) or photographs of our members or sessions, even by our members or therapist, except for clinical notes made by the therapist.
4. I promise not to seek information beyond what is offered by members during the group about other members, either online or through any other methods.
5. I promise not to tell anyone outside the group about any of the problems, histories, issues, or other facts presented by any group member, even if I conceal the name of the member.
6. I understand and agree that if I break rules 1–5 even without meaning to, I may be asked to leave the group. If I ever break one of these rules on purpose, I will be asked to leave the group. I will also face a possible lawsuit in which I may have to pay damages. If I reveal private information, I give the offended person or persons the right to recover for damages to his, her, or their reputation or other losses or harms. Also, this

person or persons may recover for any other damages, losses, or harms that can be proven.

7. I understand and agree that the therapist will keep progress notes on each individual member, and that this record will not contain information by which any other members can be identified. This record, kept in each member's name, can be shared with other professionals only with the member's written consent or to meet legal or program requirements.
8. I understand that the therapist will keep another record about the group's meetings and the interactions of the members, and that this record will not be included in any member's records. This record will be kept confidential according to legal standards.
9. I understand that I am expected to arrive for sessions clean and sober and not under the influence of any substance and that smoking, including e-cigs, will not be permitted at all during sessions.

I have read the points stated above, have discussed them when I was not clear about them, and have had my questions answered fully. I understand and agree to them, as shown by my signature below.

_____	_____	___/___/___
Signature of group member	Printed name	Date
_____	_____	___/___/___
Signature of parent/guardian	Printed name	Date

I have discussed the issues above with the client (and/or his or her parent or guardian). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent, informed and willing to consent to this treatment.

_____	_____	___/___/___
Signature of therapist	Printed name	Date

Consent to Release Confidential Information

When completed, this form authorizes the Love Counseling and Consulting LLC to release/ receive/ exchange protected health information about you or from your clinical record to/ from/ with the person(s) or organization(s) designated.

I authorize Love Counseling and Consulting LLC to release and/or exchange the following information:

- Complete copy of file or chart
- Diagnosis/ testing/ assessment results
- Psychotherapy notes
- Attendance and progress in treatment
- Clinical issues as they arise in treatment
- Other information:_____
  _____
  _____

This information should be released to, received from, and/or exchanged with:

Child and Family Service
392 N. Market St
Wailuku, HI 96793
(808) 877-6888

I am requesting my provider to release/receive/exchange this information for the following reason(s): Coordination of services, supervision, program effectiveness, treatment compliance, attendance, and progress.

This authorization shall remain in effect until (fill in expiration date). _____

You have the right to revoke this authorization, in writing, at any time by sending written notification to my office address. However, your revocation will not be effective if Love Counseling and Consulting LLC has already contacted the designated individual(s) or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and Love Counseling and Consulting LLC is not responsible for recipient(s) use of the information once released.

_____	_____	____/____/____
Signature of client	Printed name	Date
_____	_____	____/____/____
Signature of parent/guardian	Printed name	Date

Consent to Release Confidential Information

When completed, this form authorizes the Love Counseling and Consulting LLC to release/ receive/ exchange protected health information about you or from your clinical record to/ from/ with the person(s) or organization(s) designated.

I authorize Love Counseling and Consulting LLC to release and/or exchange the following information:

- Diagnosis/ testing/ assessment results
- Attendance and progress in treatment
- Clinical issues as they arise in treatment
- Other information:_____
  _____
  _____

This information should be released to, received from, and/or exchanged with:

Child Welfare Services
_____ or social worker/ supervisor assigned to case.
1885 Main St #306
Wailuku, HI 96793

I am requesting my provider to release/receive/exchange this information for the following reason(s): Coordination of services, supervision, program/ treatment compliance, attendance, and progress.

This authorization shall remain in effect until (fill in expiration date). _____

You have the right to revoke this authorization, in writing, at any time by sending written notification to my office address. However, your revocation will not be effective if Love Counseling and Consulting LLC has already contacted the designated individual(s) or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and Love Counseling and Consulting LLC is not responsible for recipient(s) use of the information once released.

_____	_____	___/___/___
Signature of client	Printed name	Date
_____	_____	___/___/___
Signature of parent/guardian	Printed name	Date

Consent to Release Confidential Information

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I authorize Love Counseling and Consulting LLC to release and/or exchange the following information:

- Diagnosis/ testing/ assessment results
- Attendance and progress in treatment
- Clinical issues as they arise in treatment
- Other information:_____
  _____
  _____

This information should be released to, received from, and/or exchanged with:

Aspire Psychological Services LLC

Stephanie Dixon, PhD, LMHC
PO Box 2744 Ewa Beach, HI 96706
(808) 285-6230
sdixon@hotmail.com

I am requesting my provider to release/receive/exchange this information for the following reason(s): Coordination of services, supervision, program/ treatment compliance, attendance, and progress.

This authorization shall remain in effect until (fill in expiration date). _____

You have the right to revoke this authorization, in writing, at any time by sending written notification to my office address. However, your revocation will not be effective if Love Counseling and Consulting LLC has already contacted the designated individual(s) or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and Love Counseling and Consulting LLC is not responsible for recipient(s) use of the information once released.

_____	_____	___/___/___
Signature of client	Printed name	Date
_____	_____	___/___/___
Signature of parent/guardian	Printed name	Date

Consent to Release Confidential Information

When completed, this form authorizes the Love Counseling and Consulting LLC to release/ receive/ exchange protected health information about you or from your clinical record to/ from/ with the person(s) or organization(s) designated.

I authorize Love Counseling and Consulting LLC to release and/or exchange the following information:

(check all that apply)

- ○ Complete copy of file or chart
- ○ Diagnosis/ testing/ assessment results
- ○ Psychotherapy notes
- ○ Attendance and progress in treatment
- ○ Clinical issues as they arise in treatment
- ○ Other information:_____

  _____

  _____

This information should be released to, received from, and/or exchanged with:

Name of person(s)/ organization/ agency: _____

Relationship to Client: _____

Contact information: _____

I am requesting my provider to release/receive/exchange this information for the following reason(s): Coordination of services, supervision, program effectiveness, treatment compliance, attendance, and progress.

-OR-

Other: _____

This authorization shall remain in effect until (fill in expiration date). _____

You have the right to revoke this authorization, in writing, at any time by sending written notification to my office address. However, your revocation will not be effective if Love Counseling and Consulting LLC has already contacted the designated individual(s) or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and Love Counseling and Consulting LLC is not responsible for recipient(s) use of the information once released.

_____	_____	___/___/___
Signature of client	Printed name	Date
_____	_____	___/___/___
Signature of parent/guardian	Printed name	Date

Consent to Release Confidential Information

When completed, this form authorizes the Love Counseling and Consulting LLC to release/ receive/ exchange protected health information about you or from your clinical record to/ from/ with the person(s) or organization(s) designated.

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(check all that apply)

- ○ Complete copy of file or chart
- ○ Diagnosis/ testing/ assessment results
- ○ Psychotherapy notes
- ○ Attendance and progress in treatment
- ○ Clinical issues as they arise in treatment
- ○ Other information:_____

  _____

  _____

This information should be released to, received from, and/or exchanged with:

Name of person(s)/ organization/ agency: _____

Relationship to Client: _____

Contact information: _____

I am requesting my provider to release/receive/exchange this information for the following reason(s): Coordination of services, supervision, program effectiveness, treatment compliance, attendance, and progress.

-OR-

Other: _____

This authorization shall remain in effect until (fill in expiration date). _____

You have the right to revoke this authorization, in writing, at any time by sending written notification to my office address. However, your revocation will not be effective if Love Counseling and Consulting LLC has already contacted the designated individual(s) or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and Love Counseling and Consulting LLC is not responsible for recipient(s) use of the information once released.

_____	_____	___/___/___
Signature of client	Printed name	Date
_____	_____	___/___/___
Signature of parent/guardian	Printed name	Date

Client Satisfaction Survey

The purpose of this survey is to help the therapist improve services in order to provide the best treatment possible. Please answer all questions honestly. Your feedback on this Survey will not be used against you in any way and will not impact the therapist's willingness to provide treatment for you in the future.

Client's name: _____ Today's date: ____/____/____

Termination/Discharge Status: _____

For each question, please circle a number to show how much you agree with the statement. Choose a number from 1 = "I completely **disagree**" to 7 = "I completely **agree.**" If the statement doesn't apply to your experience, circle NA.

	Disagree						**Agree**	
1. I was treated with courtesy and respect by the therapist.	1	2	3	4	5	6	7	NA
2. I was treated with courtesy and respect by the polygraphist and psychosexual evaluator.	1	2	3	4	5	6	7	NA
3. I felt that the therapist was appropriately concerned about my problem.	1	2	3	4	5	6	7	NA
4. The therapist seemed well trained and skilled in helping me with my concerns.	1	2	3	4	5	6	7	NA
5. The therapist helped me to be comfortable enough to express what I was thinking and/or feeling.	1	2	3	4	5	6	7	NA
6. The workbook assignments helped me better understand myself and my offense.	1	2	3	4	5	6	7	NA
7. After my first (intake) session, I started group therapy right away.	1	2	3	4	5	6	7	NA
8. I was able to take full responsibility for my offense.	1	2	3	4	5	6	7	NA
9. The therapist valued me and did not judge me.	1	2	3	4	5	6	7	NA
10. The therapist helped me to learn from my mistakes.	1	2	3	4	5	6	7	NA
11. My group was helpful.	1	2	3	4	5	6	7	NA
12. I was able to help others in my group.	1	2	3	4	5	6	7	NA
13. In general, this treatment program was helpful to me.	1	2	3	4	5	6	7	NA
14. I believe that any information collected about me will be treated confidentially.	1	2	3	4	5	6	7	NA
15. If I felt I wanted therapy again, I would return to this therapist.	1	2	3	4	5	6	7	NA
16. I would recommend this therapist to others, even if their struggles were different than mine.	1	2	3	4	5	6	7	NA

Please feel free to write additional comments on the back of this page.