**David W. McMillan, Ph.D.**

**Confidential Information – Youth**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Please Print)**

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First Middle Last

Age Date of Birth \_\_\_\_ Sex: Male Female Home phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address

street city state zip

Mother’s name

Legal custody of youth?  Yes  No

first

Mother’s address

street city state zip

Mother’s occupation Employer

Mother’s home phone Mother’s work phone

Father’s name

Legal custody of youth?  Yes  No

Father’s address

street city state zip

Father’s occupation Employer

Father’s home phone Father’s work phone

Name of other legal guardian Work phone

Guardian’s address Home phone

Guardian’s relationship to youth

***Youth’s Immediate Family (for younger children, include all persons other than parents living with the child)***

Name Relationship Age Occupation/Grade Residence

Youth’s school Teacher

Grade Special classes

**Please complete the following medical information:**

Family physician: \_\_\_\_\_\_\_ Date of youth’s last medical examination

If youth is currently under the care of a physician for a continuing Health Problem, please give the physician’s name and phone number:

Do youth take regular medications? If so, what?

Name of medication Dose Frequency

Does youth smoke? If so, how much? How long?

**Previous Mental Health Services:**

Type of Service Provider Dates of Service

**Current or expected legal involvement?** Yes No If yes, please explain:

**Referred by:** Relationship

**Person to notify in case of emergency:** Relationship

Address: Phone:

street city state zip home work

**Payment Information**

Financially responsible party: Self  Other  If self, give billing address below:

**Please provide the following information about the Financially Responsible Person, If it is not the patient:**

Name: Age SS#

Relationship to patient: Home phone: Work phone:

Employer: Occupation:

Billing Address:

**Fees:**

My fee is $225.00 for individual and $225.00 for family/couples per a 50-minute appointment. Special fee structures for certain specified tasks such as psychological testing, consulting, or court-ordered appearances will be discussed with you and agreed upon before any actions are taken.

While Tennessee law permits minors sixteen years and older to consent to mental health care without parental consent, I expect minors to obtain permission from their parents and their parents to be responsible for payment.

I do not take insurance, nor do I participate in “manage care,” HMOs, PPOs, or other health care insurance programs

Payment is due at the time services are delivered.

**Appointments:**

My secretary typically schedules my appointments for my patients but sometimes she is not available and I will schedule the appointments for myself.

Since patients are seen by appointment only (*unless an emergency situation dictates otherwise*), the appointment time given is reserved for you. Please give at least forty-eight (48) hours’ notice if you must cancel your reserved time. In the absence of such circumstances, you will be charged your usual fee for appointments not cancelled twenty-four hours prior to the time.

**Emergencies and Telephone Calls:**

While you will be seen at a reserved time, which fits your schedule demands and my availability, there may arise occasions where you need to talk to me between appointments. Should you need to talk to me between appointments and you call during normal office hours, I will return your call as promptly as I can. However, I am often unavailable for emergencies. If you are in a crisis and you require an immediate response or a response before I can get back to you, call 911 or call the Crisis Center at 615-244-7444 or go to the nearest emergency room. If this is not an emergency you can reach me at either 615-327-2183 office (preferably) or 615-347-0243 my cell. I understand that there are limitations to telecommunications therapy, e.g., interruption of service, the potential risk for compromised confidentiality, an understanding of proposed alternative ways of reconnecting.

**Confidentiality: (Privacy and trust are essential for successful treatment.)**

The Tennessee Code Annotated (TCA 63-11-213) provides that “…the confidential relations and communications between licensed psychologist…and client are placed upon the same basis as those provided by law between attorney and client…”

The legal client(s) controls the release of confidential information.

Authorization the release of confidential information obtained in joint sessions must be approved by both parties and documented in writing.

Should an adult member be seen individually, the information disclosed in that context is controlled by the individual.

Records regarding minors are available to both parents.

All Protected Health Information (PHI) (e.g., the entire administrative and clinical records) is confidential and privileged and is protected by TN Laws and the Federal Government’s HIPPA laws.

PHI includes (but is not limited to) administrative information (appointments, fee accounting, etc.) and documents provided to the Consultant. Clinical information obtained and/or generated by the Therapist-consultant during this engagement, including treatment plans, progress and case notes, test results, diagnostic records, etc.

All interactions which take place with a psychologist are considered confidential and cannot be disclosed without legal authorization. This information includes data obtained by telephone, via Zoom or other technologies, and face-to-face interactions with the psychologist, including scheduling or appointment notes, all session content records, and any progress notes taken during your sessions. I will not even verify that your child is a client. No information can be released without your joint authorization. You may choose to give me permission in writing to release any or specific information about you to any person or agency that you designate.

**Pending and/or Future Litigation, or other Forensic Matters:**

My objective is to be your therapist—not a judge, arborator, or evaluator, therefore:

My sole objective is to provide a safe, confidential, therapeutic context, where there is no shadow of a doubt that the information can be (or will be) used for any other purpose than for therapy.

Furthermore,

The purpose, procedures, and professional standards for providing counseling and psychotherapy are different from conducting a differential diagnosis and/or providing forensic services.

Therefore,

I will not change my role professional duties as a therapist to perform other types of professional services without negotiating a new agreement with all the parties.

**Records:**

Telehealth sessions will not be recorded by Dr. McMillan. All persons invited to hear or participate in that session will be agreed upon by the client and Dr. McMillan and this will be reflected in the notes.

The creation and control (e.g., the storing, accessing, transferring, retention and disposal) of records in any medium are governed by Professional Standards (APA Ethical Standards #1.23; 1.24; 5.04 and 5.05) and by Tennessee state Law, including paragraphs in HRB’s Rules and Regulations (R&R #1180, etc.).

The Consultant-Therapist finds limited clinical value in generating extensive treatment records. Unless the legal client(s) request otherwise, I will limit the content of these clinical records to be consistent with minimal standards.

Records are NOT stored in databases used for research or disclosed to third parties, such as insurance carriers, etc.

The information in the couple’s and family’s files is available to the legal clients.

**Your Informed Consent to Care:**

I have provided this information to you in the hope of fully informing you about the policies of my office and some of the parameters of care you will receive here, such as the importance of confidentiality. Psychiatric and psychological care, like other things in life, offer no absolute guarantee of success and there are limitations to any form of care offered a patient. Since such limitations are always a function of the particular problem in question, I invite you to discuss your treatment plan with me. After we have met to discuss your concerns, I will construct an individualized treatment plan and share it with you so that you and I have our plan for what problems we are going to solve and how.

Please feel free to discuss any of these matters with me in more detail. By signing below, you acknowledge having read, understood, and agreeing to these policies and procedures. Your signature acknowledges your informed consent for care.

**Quality Assurance:**

I aspire to provide the highest quality of professional services. To this end, I routinely consult with trusted colleagues. In these cases, no personally identifiable information is used. This process is consistent with the best professional practices, which are consistent with state and federal laws.

The professionals with whom I may discuss cases are legally bound to keep the information confidential. (I will be glad to identify the professional individuals I routinely consult with.)

**Parent Authorization for Minor’s Mental Health Treatment**

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.  
  
If you are separated or divorced from the child’s other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment. I also hope to meet with both parents and be equally accessible to them when possible unless otherwise indicated by my judgement or by the court.  
  
One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child’s treatment. 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, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

**Individual Parent/Guardian Communications with Me**

In the course of my treatment of your child, I may meet with the child’s parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child. If I meet with you or other family members in the course of your child’s treatment, I will make notes of that meeting in your child’s treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child’s treatment record.   
  
**Mandatory Disclosures of Treatment Information**

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child’s permission. I have listed some of these situations below.  
  
**Confidentiality cannot be maintained when:**

Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.

Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].

Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused (physically, sexually or emotionally) or that it appears that

they have been neglected or abused in the past. In this situation, I am [may be] required by law to report the alleged abuse to the appropriate state child-protective agency.

If parents are divorced and meet together with me, confidentiality is not legally vested.

I am ordered by a court to disclose information.

**Disclosure of Minor’s Treatment Information to Parents**

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a “zone of privacy” where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.  
  
It is my policy to provide you with general information about your child’s treatment, but NOT to share specific information your child has disclosed to me without your child’s agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child’s risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

*Example*: If your child tells me that they have tried alcohol at a few parties, I would keep this information confidential. If you child tells me that they are drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.

*Example*: If your child tells me that they are having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of “hypothetical situations,” such as: “If a child told you that they were doing \_\_\_\_\_\_\_\_, would you tell the parents?”  
  
Even when we have agreed to keep your child’s treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child’s life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so.   
  
Also, when meeting with you, I may sometimes describe your child’s problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

**Disclosure of Minor’s Treatment Records to Parents**

Although the laws of [this State] may give parents the right to see any written records I keep about your child’s treatment, by signing this agreement, you are agreeing that your child or teen should have a “zone of privacy” in their meetings with me, and you agree not to request access to your child’s written treatment records.

**Parent/Guardian Agreement Not to Use Minor’s Therapy**

**Information/Records in Custody Litigation**

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child’s parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent’s custody, visitation suitability, or fitness. 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(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $XXX per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

**CONSENT AND AGREEMENTS**

**Child/AdolescentPatient**

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor’s Signature\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian of Minor Patient**

Please initial after each line and sign below, indicating your agreement to respect your child’s privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child’s/adolescent’s treatment.

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist’s professional judgment, unless otherwise noted above.

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

\* For very young children, the child’s signature is not necessary

*Thanks to Sherry Kraft, Ph.D., clinical psychologist for The Center for Ethical Practice, for use of some the examples and concepts in the child/adolescent portion of this template informed consent.* [*http://www.centerforethicalpractice.org*](http://www.centerforethicalpractice.org)

**PATIENT NOTIFICATION OF PRIVACY RIGHTS**

The Health Insurance Portability and Accountability Act (HIPAA) has created new

patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law”, HIPAA provides patient protections related to the electronic transmission of data (“the transaction rules”), the keeping and use of patient records (“privacy rules”), and storage and access to health care records (“the security rules”). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. My Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can do protect the privacy of your mental health records. In the event that my role changes so that I have a forensic psychology role that involves the legal system or the courts, the privacy rights contained in this contract no longer pertains. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, as a licensed clinical psychologist, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

David W. McMillan, Ph.D.

Licensed Clinical Psychologist (#P0000000523)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand and have been provided a copy of Dr. McMillan’s Patient Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I am consulting with Dr. McMillan because I want his clear unvarnished frank opinions and I hope he can provide helpful guidance. I understand I have the right to review this document before signing this acknowledgment form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature or Parent if Minor or Legal Charge Date

If Legal Charge, describe representative authority: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_