CDH CONNECTIONS INC.
~compassionate development for healing~

CANDACE DAVIS HAWKINS, MSW, LCSW-C
PSYCHOTHERAPY AND CONSULTATION

PRACTICE AGREEMENT AND INFORMED CONSENT

The confidential nature of information you share with me is one of the most important things to understand. Ordinarily, any therapeutic information you share with me is strictly confidential—whether you say it in person, say it on the telephone, or write it, the information will be recorded in your clinical record. Other parts of our conversations may not relate and will not be recorded.

If we mutually decide that I should provide some part of your confidential information to another professional, your insurance company, your attorney, or even you, you will sign a specific and time-limited release of information stating what is to be released, to whom, and how the information will be used.

There are four circumstances in which I would be required by law to reveal confidential information about you without your consent. 1. I learned that you were in serious danger of harming yourself or at serious risk for harming another person, 2. I learned that you were abusing or neglecting a child, an elderly person, or a disabled person in your care, 3. In the event of a court order compelling me to release your clinical record to a court of law, and 4. If you were the victim of suspected or committed child abuse, even if you are reporting the matter as an adult and even if the matter was previously reported. I will make every effort to keep you involved in the reporting process when your involvement is therapeutically necessary.

If you are utilizing insurance, please note that insurance companies require a psychiatric diagnosis on all submitted claim forms and want information on your symptoms and progress to continue authorizing care. Your signature on the Fee Policy and Agreement provides permission to release this information. If you do not wish to utilize insurance, you will be responsible for paying the full consultation fee. All payments are expected at the beginning of the session.

My emergency telephone number for crisis involving threat to yourself or someone else is 410.984.8060. If I do not answer, please contact 911 or visit your nearest emergency room.

If we discover that, despite our best efforts, you are not making progress in meeting your goals, we will talk about several options: consulting with colleagues whom I know well and respect highly, seeking guidance from a specialized consultant or referring you directly to someone else for further assessment or for specific services that I am unable to provide. Finally, if I determine that your best interests are not being served in working with me, then we will end our service relationship. You have the right to reject services at this practice at any time.

In that event, we will work closely together to connect you with professional help that will meet your needs. At our last contact, your case will remain open for 90 days. Please be assured that if you decide, you may contact me to resume services in the future.

Client Signature: _____ Date: _____

Signature (Parent/Guardian if under the age of 18) _____Date: _____