Metro West Center for Well Being Confidentiality Contract

During professional services provided by a licensed psychiatrist or therapist, the confidentiality of the process is recognized as privileged communication. The privilege is the client's, not the psychiatrist/therapist's to invoke or waive. Accordingly, should the records be sought by subpoena or other legal instrument, it is necessary that the client make know any determination not to release the records. If the client determines that the records should be released under such circumstances, it is important to note that confidentiality is "all" or "none". In other words, you may ask that a response be made to inquiries, but you cannot ask that some questions be answered and not others.

Additional exceptions to confidentiality should be noticed. First, any stated or implied intent to endanger self or others negates confidentiality and in face, obligates the therapist/doctor to inform others. Secondly, like other professionals in health and education, the therapist/doctor are obligated to report any indication or child, elder or handicapped person abuse or neglect to the Department of Social Services. Thirdly, your contract with your health insurance company that you ask to bill for your services typically includes a provision, signed by you when you subscribed, authorizing release of records upon request by that company and/or by the managed care organization that may work with your insurance carrier. When audits occur, some companies permit "whitening out" of your name while others do not.

You may call the office at any time at (508) 376-6018. During non-office hours, you may leave a message on our voice mail. Messages left are checked and returned by office staff during office hours. **In an emergency, go to the nearest emergency room and have their staff contact Megan Bickford on her cell phone (617) 417-7426.** Patients and/or guardians may contact Megan on her cell phone for **urgent** calls/texts only. Emails may be sent to mbickford.cwb@gmail.com .

Should any concerns or complaints emerge during our work together at the Metro West Center for Well Being, please present them as soon as possible to any member of our staff, and they will be addressed. We hope for a positive experience in your and/or your child's journey towards personal well-being.

I have read and understood the above information about confidentiality, emergencies and concerns. I understand the proposed treatment plan and goals and I am in agreement with them. I acknowledge having received a copy of a document detailing my patient's rights. I am hereby assigning payment for services to the Metro West Center for Well Being, LLC.

Before signing below, please ask for further explanation or clarifications of any of those points that may remain unclear.

I UNDERSTAND AND AGREE TO THE ABOVE.

_____

Signature of patient or parent/guardian of minor child Date

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Full legal name of patient(s)