# INFORMATION FOR CONSENSUAL CONSULTATION AND/OR TREATMENT

**Your decision to engage in mental health care services begins with an understanding of the process. The following information is provided so that you may make an informed decision about such services. It is important that you read it and ask me any questions you have about the material it contains.**

**Please check the box for your provider:**

☐ Samuel D. Smithyman, Ph.D.

During the *initial consultation(s)*, we will work together to establish an understanding of the nature of your needs, concerns, and goals. This will in most cases lead to a formal diagnosis, and in some cases, more than one consultation session will be needed to establish relevant current and historical information.

If, as a result of your initial consultation(s) with me, it appears that individual or group *psychotherapy* or marital/couples or family therapy might be beneficial to your concern(s), then we may agree to meet for psychotherapy sessions, which generally occur on a regularly scheduled and consistent basis. If it appears that I would not be an appropriate provider of further assistance, then I will suggest alternatives and make referrals accordingly. If we are not able to meet on a schedule that that is comfortable for you or that does not meet your needs (e.g., when we cannot meet often enough), I will be happy to suggest alternatives and make referrals accordingly.

### *Confidentiality*

I maintain detailed records of all contacts with my patients for at least six years following the termination of our work together in accordance with the laws of the State of South Carolina. With certain exceptions, all work and communication between psychologists and their patients is confidential under State law, with further protections afforded by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which are reviewed in a separate Notice. I would release or share information about you only in accordance with HIPAA and other relevant state laws. If and when I receive communications about you from others (e.g., calls from family members who are concerned about you) I will in most cases inform you of the contact at the next available opportunity. I may listen to their concerns if I deem them appropriate and relevant, but I will not discuss you with them, disclose any information about you or your diagnosis or treatment without your prior written authorization.

### *Exceptions to Confidentiality*

There are some potential exceptions to the general rule of confidentiality. Certain Federal and State laws and other special circumstances may necessitate exceptions to the general expectation of confidentiality. Some of the most prominent and important exceptions include:

* THREATS OF HARM: If you threaten to harm either yourself (e.g., suicide threats) or someone else and I believe your threat to be imminent, I am required by law to take whatever actions seem necessary to protect you and/or others from harm. This may include my divulging confidential information to others, including the appropriate authorities. Even if a potential threat is not imminent, I reserve the right to contact spouses, family members, and/or other significant persons so that I may enlist their assistance in helping you to manage yourself. Similarly, if you express an intention to commit a crime that endangers yourself or others, I am allowed by law to disclose confidential information if this is necessary to prevent the crime.
* ABUSE OR NEGLECT: If you indicate, directly or indirectly, that you or someone you know is or may be abusing or neglecting a child, an elderly person, or an otherwise impaired person

(e.g., a mentally retarded adult), then I am required by law to report this to the proper authorities.

* COURT ORDERS: If you are (or become) involved in litigation of any kind and it becomes known that you have received mental health services (thereby making your mental health an issue before the court), you may be waiving your right to keep your record confidential. You may wish to consult with your attorney about these matters before you disclose that you have received treatment. I will attempt to protect your confidentiality appropriately, but if a court order is issued for your record, State law dictates that I must comply.

* MINORS AND WARDS: If you are a legal minor (i.e., a non-emancipated person under 18 years of age) or you otherwise have one or more legal guardian(s), then your legal guardian(s) is(are) considered by law to be the one(s) responsible for making treatment decisions, including decisions about what access is allowed to your treatment record. In most cases, I ask the legal guardian(s) to waive his/her/their rights in this regard and to allow you to be treated as if you were able to make those decisions for yourself. These can be complex situations that are best dealt with on a case-by-case basis.

* FAMILY/MARITAL: If treatment involves others close to you, such as your spouse, child(ren), friends, etc., then we will need to clarify my role in relation to each person. In most cases, there is only one identified patient, and my allegiances will be first and foremost to that person. But there are exceptions, such as when I am providing marital therapy to two persons, in which case the *relationship* is the "patient" and therefore I cannot "take sides" with either person (e.g., testify for one or the other in divorce or child custody disputes).

* COLLECTION OF FEES: If I must resort to the use of a collection agency in order to receive payments due for psychological services, I am allowed by law to release confidential information without patients' consent.

South Carolina provides the consumer the opportunity to file inquiries with its Board of Examiners in Psychology.
Board offices may be reached at:

**South Carolina Board of Examiners for Psychologist, Counselors, & Therapists**
**PO Box 11329**
**Columbia, SC 29211-1329**

By your signature, you acknowledge that I have provided you a copy of the *Information for Consensual Consultation and/or Treatment.* You also acknowledge that consultation or treatment will be provided by Samuel D. Smithyman, Ph.D.. You affirm that you have reviewed this information, that you have had an opportunity to clarify your understanding of my practice, and that you consent to engage in treatment according to the terms described in it. You also consent to the releasing of information about you to your insurance company (if applicable) and/or my billing agency (if applicable) for collection of fees. **You acknowledge that you have been offered a copy of my Notice that is posted on my website at www.sdsmithyman.com.**

Please print
Your name: _____ SSN: _____

Your
signature: _____ Date: _____

Witnessed by
interviewer: _____ Date: _____
Provider