



## “NO SECRETS” POLICY FOR COUPLE OR FAMILY TREATMENT

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (i.e., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen, the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

### **PARTICIPATING FAMILY MEMBERS**

Name \_\_\_\_\_ *please print*

Name \_\_\_\_\_ *please print*

Name \_\_\_\_\_ *please print*

Name \_\_\_\_\_ *please print*

Name \_\_\_\_\_ *please print*

Name \_\_\_\_\_ *please print*

We, the members of the couple/family/other unit being seen, acknowledge by our signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with the therapist or representative of Compass Professional Services LLC, and that we enter couple/family therapy in agreement with this policy.

Client Signature \_\_\_\_\_

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Client Signature \_\_\_\_\_

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_ *mandatory if client is a minor*

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_ *mandatory if client is a minor*

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Therapist/Representative of Compass Professional Services LLC \_\_\_\_\_

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_