

# Alanna M. Lipinski, Ph.D.

450 Central Avenue Suite 201 Lancaster, NY 14086

716-221-0363

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## **ADOLESCENT CONFIDENTIALITY AGREEMENT**

**(Age 13 and older)**

The reason for working with a therapist is to improve things in your life that are troublesome or that are keeping you from being your best. You may have wanted to talk to someone or your parent, guardian, teacher, or doctors are concerned about something. The number of sessions we meet together will be agreed upon by us as a team (you, me, and your parents). Most often, people stop coming to therapy once they develop skills to help them feel better.

When we first meet, my goal is to see if I am a *good fit* to help you with your concerns. I will listen to you and help you develop a plan. Trust between us will take some time to develop. To help with this, please know that specific information you share with me is kept between us. This is called confidentiality.

### **Confidentiality and Limits**

In general, I will keep what you say confidential, which means between you and I. There are some limits:

- If you tell me you plan to cause serious harm to yourself, and I believe you will do this, I must take steps to protect you. This includes telling your parent. If I am concerned about this, it will not be a secret. I will tell you right away and we will figure out the best plan to keep you safe.
- If you tell me you plan to cause serious harm to someone else, and I believe you, I must inform your parent/guardian, the person you intend to do harm to, and possibly law enforcement. Again, this will not be a secret.
- If you are doing things that could cause serious harm to you or someone else, even if you are not intentionally trying to harm yourself, I will use my best judgement to decide if your parents need to know.
- If you tell me you have been abused in the past or are being abused currently, I will be required to make a report to Child Protective Services (CPS).
- If you are involved in a court case or your parents are involved in a court case and I receive a request for information about our work together. I will do all that I can to protect your confidentiality. If I am required by law to give information, you will be informed.

If there is something you tell me that I believe is important for your parent/guardian to know but it is not something I consider of serious risk to you, I will encourage you to tell them. We can develop the best way possible together. Working with your parents is very important. This is so they know our goals and can help you to make the most progress. With your permission, your parent may sit in on sessions. If your parent does not take part in the session, I will tell your parent a) goals we are working on; b) skills I may have taught you; c) my impressions of your progress; and d) how they can best support you in between sessions.

## **ADOLESCENT SIGNATURE**

**Alanna M. Lipinski, Ph.D.**

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I have reviewed the information above and understand confidentiality and its limits. I understand I can ask questions to my therapist at any time about confidentiality and its limits.

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Adolescent's Signature

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Date

**PARENT GUARDIAN SIGNATURE**

I will refrain from requesting detailed information about individual therapy with my child. I understand I will be provided with information about a) goals my adolescent is working on; b) skills my adolescent is being taught; c) Dr. Alanna Lipinski's impressions of my adolescent's progress; and d) how I can best support my adolescent in between sessions. I understand that Dr. Alanna Lipinski will only breach confidentiality if my adolescent is in serious danger to him/herself, is in serious danger to another, has reported abuse (physical, sexual, emotional, neglect), or it is mandated by law in a court proceeding.

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Parent Signature

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Date

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Alanna Lipinski, Ph.D.

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Date