

Susan J. Bramlette, LMFT

1751 River Run. Suite 200, Fort Worth, TX 76107

Phone: (512) 356-9238

Fax: (512) 233-1021

<http://www.susanbramlette.com>

Couples and Families: Please review and sign below. Thank you!

**LIMITATIONS OF CONFIDENTIALITY WHEN WORKING WITH COUPLES OR FAMILIES
(THE “NO SECRETS” POLICY):**

In my Professional Disclosure Statement you read about the legal issue of confidentiality that I will not release any information about our sessions to a third party without your written permission. The exceptions to this would include instances where I legally have to report concerns about your safety or the safety of others or if I am subpoenaed to disclose information.

In our work together, I may choose to see you or a part of your family separately. This will be considered part of our course of therapy and confidentiality as stated above and in the Professional Disclosure Statement still applies. However, there may be instances in which I need to share information learned in an individual session with your partner or other family member. I will use my best clinical judgment as to whether, when and to what extent I will make those disclosures to others involved in the therapy process. I will also give the individual the option and opportunity to share that information with the other(s) or larger part of those involved in the therapy process. If you feel it necessary to talk about matters that you absolutely do not want the other(s) to know, 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 those involved in the therapy process. For instance, information learned during an individual session may be relevant or even essential to the proper treatment of the couple or family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the couple or family, I might be placed in a situation where I will have to terminate treatment of the couple or family. This policy is intended to prevent the need for such a termination.

By signing below, you as members of the couple/family or other unit receiving services/therapy acknowledge that each of you has read and understand this policy, that you have had an opportunity to discuss its contents with me as your therapist and that you undertake couple/family therapy in agreement with this policy.

Date: _____ Signature: _____
Date: _____ Signature: _____