

INFORMED CONSENT FOR PSYCHOTHERAPY

NATURE OF THE RELATIONSHIP: The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. Our contact will be limited to counseling, coaching, or consultation sessions you arrange with me. Preserving the integrity of our professional relationship means that clear distinctions must be drawn from a personal relationship. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

THE THERAPEUTIC PROCESS: You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

EFFECTS OF PSYCHOTHERAPY/COUNSELING or COACHING: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing or discontinuing counseling/psychotherapy or coaching. While benefits are expected from counseling/psychotherapy or coaching, specific results are not guaranteed. Counseling/psychotherapy is a personal exploration and may lead to major changes in your life perspective and decisions you make. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

CLIENT RIGHTS: Some clients only need a few counseling sessions to achieve their goals; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though I do request you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might not be beneficial to you. I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please notify me in person or in writing, and I will work with you to resolve your concerns. It is my pledge that I will work to resolve any problems to your satisfaction.

REFERRALS: Having an effective working relationship is of utmost importance to me and is critical for successful outcomes in counseling/psychotherapy. Should you and/or I believe that a referral is needed for more extensive or additional services, I will provide some alternatives including programs and/or professionals who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives.

CONFIDENTIALITY: Communication between you and your therapist is confidential and will be protected as such, with the exceptions of information that cannot be protected, as detailed in "Notice of Privacy Practices" and listed below. Your written consent must be given to release information to another party. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under 18.
4. Suspicions as stated above in the case of an elderly or disabled person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If therapist has a reasonable suspicion of sexual contact with another mental health professional.
7. If a court of law issues a legitimate subpoena for information stated on the subpoena.
8. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

MARRIAGE AND FAMILY COUNSELING: In the case of marriage or family counseling, I will keep confidential (within the limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members and I reserve the right to terminate the counseling relationship if I judge a secret to be detrimental to the therapeutic process.

CONSULTATION: Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

RECORD KEEPING: All of our communication becomes a part of the clinical record, and how that record is handled and protected is detailed in the "Notice of Privacy Practices" document. Physical records are kept in a locked file and electronic records are kept in a HIPPA compliant, secure, web based program. Adult client records are disposed of seven years after the file is closed. Minor client records are disposed of seven years after the client's 18th birthday. The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons, and the request is relevant according to existing state and federal rules regarding records.

PROTECTION OF RELATIONSHIP OUTSIDE THE THERAPY SESSION: Because your privacy and confidentiality is of utmost concern to me, if we see each other accidentally outside of the therapy office, I will not acknowledge you first. However, if you acknowledge me first, I will be more than happy to speak briefly with you, and any information shared in sessions will not be discussed in public.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Printed Name

Date

Client Signature

Date

Legal Guardian (if client is under 18) Printed Name

Date

Legal Guardian (if client is under 18) Signature

Date