INFORMED CONSENT FOR THERAPY SERVICES

THERAPIST-CLIENT SERVICE AGREEMENT: This document contains important information about my therapy services, policies, and procedures. It also contains important information that you should familiarize yourself with about the Health Insurance Portability and Accountability Act (HIPAA). HIPPA is a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Your signature on this document also represents an agreement between us. You are welcome to bring up any questions or concerns that you may have anytime during this intake or throughout your treatment.

PSYCHOLOGICAL SERVICES Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. As your therapist, I also have legal and ethical responsibilities to properly manage your care. These rights and responsibilities are described in the following sections. Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions. The first 2-4 sessions are usually comprised of information gathering done by completing an assessment and learning more about your presenting issues, symptoms, and reason for seeking therapy. By the end of the evaluation, I can offer you some initial impressions of what our work might include and will begin to distinguish your treatment goals.

NO-SHOW/CANCELATION POLICY: Appointments will ordinarily be 50 minutes in duration, once per week or bi-weekly at an agreed upon time. If you need to cancel or reschedule a session, I ask that you provide me with notice within 24-hours of your scheduled appointment. If you cancel after the allotted 24-hour window or do not show up to your appointment (no-show/no-call), you will incur the full fee for the late-cancellation or no-show. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL RECORDS: I am required to keep records of the psychological services provided and to ensure that your records are held safely in a securely locked location in my office. We keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records we receive from other providers, copies of records we send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, we recommend that you initially review them with your clinician, or have them forwarded to another mental health professional to discuss the contents.

CONFIDENTIALITY Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. All contacts with this office, including telephone, mail, in person interview, etc., are considered confidential and will not be shared with an outside agency or person without your prior consent, in writing. We appreciate the need for confidentiality, both in dealing with people and in keeping secure records. A number of laws govern our

clinicians, and these laws require us to report any reasonable suspicion of child abuse, which can include physical, sexual, emotional abuse, and/or neglect. We must also report any suspicion of physical abuse of a dependent adult who is 18 years or older, and we must report elder abuse, of anyone 65 years or older. In addition, if the clinician has reasonable cause to believe that you are a danger to yourself or to the person or property of another, then disclosure may be made to an appropriate person or agency to prevent the threatened danger. Please remember that you may reopen the conversation at any time during our work together.

CONTACTING YOUR CLINICIAN: I may not immediately be available by telephone, as I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or if I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, go to your Local Hospital Emergency Room, or call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional providing coverage during my absence.

OTHER RIGHTS: If you are unhappy with what is happening in therapy, I hope you will bring this up in therapy so that I can address your concerns to the best of my ability. Your feedback about my services will be handled with respect and care. You are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about your clinicians specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

I hereby consent to Couples Therapy treatment per the aforementioned terms outlined in this document:

Full Name: _____ ***Full Name:*** _____

DOB: _____ ***DOB:*** _____

Home Address: _____

Phone Number: _____ ***Phone Number:*** _____

Client's Signature: _____ ***Client's Signature:*** _____

Date: _____ ***Date:*** _____

How did you hear about me? Psychology Today, Website, Insurance List, Word of Mouth, Other