Informed Consent to Adult Psychotherapy Treatment

*Please read the following information and sign or initial where indicated. This document contains important information about my practice. During our initial appointment, I will explain each item in detail and provide a chance to have any and all questions answered.*

This is an agreement whereby, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agrees to enter into treatment with Karen Cunningham, LMFT.

**Confidentiality:**

Our communication as client and therapist, along with clinical records, is strictly confidential and can only be released with your written request. When two or more people are seen in therapy, all persons are viewed as a relational system. As such, written releases of information must be obtained from all members of the relational system who have been present at any time during therapy before information will be released.

There are some situations in which I am legally required to take action to protect others from harm, even though that may require revealing some information about a client’s treatment. Under the following circumstances, I am legally mandated to release information and/or records.

1. If I believe that a child, an elderly person, or a disabled person is being neglected or abused, I may be required to file a report with the appropriate state agency.
2. If I believe that a client is threatening serious bodily harm to another, I may be required to take protective actions, to include notifying the potential victim, notifying the police, or seeking appropriate hospitalization.
3. If a client threatens to harm him/herself, I may be required to seek hospitalization for the client, or to contact family members or others who could help provide protection.
4. If a court of law issues a court order or legitimate subpoena for information or records, I am obligated by law to comply.

**Record Keeping and Client Rights**

HIPAA provides clients with certain rights with regard to your records and disclosures of protected health information. These rights include requesting an amendment to your clinical record, requesting restrictions of what information from your clinical record is disclosed to others, requesting an accounting of disclosures of information, determining the location to which protected information disclosures are sent, having any complaints you make about policies and procedures recorded in your records, and the right to a paper copy of any agreements. A more thorough description of your rights will be offered to you and therapy will not begin until any and all questions you have are answered.

**My Practice**

Goals for therapy will be determined in a collaborative basis. Together, we will work to establish the type of therapy which you will receive and the frequency and duration of the therapy sessions.

Clients are expected to pay at the end of each session. The agreed upon fee for therapeutic services is $\_\_\_\_\_\_. Clients are expected to pay for uncancelled appointments or those where there is a failure to provide enough notice. Generally, 24 hours notice of an inability to attend a session is expected. The only exceptions are unforeseen or unavoidable situations arising suddenly.

While there is an expectation that clients will benefit from therapy, there is no guarantee that this will happen. Therapy deals with sensitive and difficult topics and it is not unusual for clients to feel at least temporarily disrupted. I ask that clients agree to keep me fully up to date about any changes in feelings, thoughts, and behaviors and understand that we will work together on any difficulties that occur, and to work them out in my long-term best interest.

 I do not provide emergency services. I do my best to answer my phone during regular business hours. If you cannot reach me and are in an emergency situation please call or go to the nearest hospital emergency room and ask for the mental health professional on call. Hospitals are mandated to provide such services. You can inform them of your work with me and provide them with a written release to contact me if more information is needed. Further, I provide clients with emergency contact numbers for such emergency cases. Clients agree to hold Karen Cunningham, LMFT, harmless and free of liability for abandonment or malpractice if I am not available during any circumstances.

These sessions are not intended to be used for litigation purposes. Clients agree not to request that I release any information nor to call me to serve as a witness in any litigation clients are currently involved in or any litigation clients may become involved in.

Clients are expected to hold themselves responsible to the commitment of the therapy sessions. Sessions will not be held if any client is under the influence of non-prescription drugs or has misused prescribed drugs, illegal drugs or alcohol. Violence (physical and/or verbal) is never acceptable. As such, if this behavior is expressed, I reserve the right to immediately stop the session and reschedule for a time when everyone can remain safe. Any form of discrimination is never tolerated.

\_\_\_\_\_\_ Please initial here to indicate that a copy of a professional disclosure statement was provided.

\_\_\_\_\_\_ Please initial here to indicate that a copy of emergency coverage policies was provided.

\_\_\_\_\_\_\_\_ Please initial here to indicate you have had a chance to review HIPPA compliant privacy practices and have any and all questions answered.

With enough knowledge and without being forced, the signee below agrees to enter into treatment with Karen Cunningham, LMFT.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I, Karen Cunningham, LMFT, have discussed the issues above with the client. My observations of this client’s behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_