

Clients Name: _____

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Informed Consent for Couples Psychotherapy

Purpose of Treatment

The purpose of couples counseling or psychotherapy is to produce change. Change encompasses helping you and your partner deal with stresses and concerns in your relationship and to achieve your relationship goals.

_____ initials

Types of Therapeutic Approaches

General Procedures: In helping you to make changes, I will focus with you on your cognition or thinking, your emotions, your behavior and your relationships with others. I will primarily utilize talk therapy, although I may provide PACT, EFT, psycho-education, ask you to engage in role playing, or assign homework. Although I provide individual, group, couples, and group therapy in my practice, this consent is for me to provide couples psychotherapy to you.

At times during the course of treatment, I may recommend adjunctive therapy. This may include referrals to a psychiatrist, your primary care physicians, support groups, or other therapists as part of your therapy with me. If another health care provider is working with one of you I require that you sign an Authorization to Release Information so that I can communicate with that person about your care. _____ initials

Potential Benefits: Counseling can help you acquire tools to develop your own solutions as well as learn how to deal with the difficulties in your relationships. _____ initials

Limitations and Potential Risks: A "fix" is not guaranteed. As your therapist, I will provide you with the highest level of professional treatment commensurate with my training and experience. Psychotherapy calls for a very active effort on your part. In order for therapy to be successful, you will both have to work on the things we talk about during our sessions and at home.

Therapy can involve discussing unpleasant aspects of your relationships and/or you may experience uncomfortable feelings. If I propose a specific technique, that may have special risks attached, I will inform you of that and discuss with you the risks and benefits of that particular technique.

You normally will decide when therapy will end. However, there are exceptions. If in my judgment, I am not able to help you because of the kind of problem you have or because my training and skills are not appropriate, I will inform you of this fact and refer you to another therapist who may better meet your needs. If you engage in verbal or physically violent behavior, or threaten to do so to myself, office members, or my family, I reserve the right to unilaterally and immediately terminate your treatment. Should this occur, I will offer referrals to other treatment providers. _____ initials

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No Secrets Policy: When a couple enters therapy, the couple is considered to be a single unit. This means that my allegiance is to the couple “unit” or the relationship, and not to either partner as individuals. This allows the therapy to create a space where both partners can feel safe. The “No Secrets” policy means that I will not hold secrets for either partner. This allows me to continue to treat the couple 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 the unit being treated. On occasion during the counseling process, partners may be seen individually for a counseling session. When this occurs, the session is still considered to be part of the couple’s counseling relationship. Information disclosed during these sessions may be relevant or even essential to the proper treatment of the couple. If an individual chooses to share information with me, I will encourage and offer the individual every opportunity to disclose the relevant information to his/her partner and I will provide guidance in this process. If the individual refuses to disclose the information within the couples session, I may determine that it is necessary to discontinue the counseling relationship with the couple. If there is information that an individual wishes to address with a context of individual confidentiality, I will be happy to provide referrals to therapists who can provide concurrent individual therapy. _____ initials

Confidentiality

In general, the privacy of our therapy sessions and communication is protected by law; I can only release information about you to others with your written permission. **Please read the HIPAA handout. It is imperative that you read and understand the limits of privacy and confidentiality before you start treatment.** _____ initials

Limits of Confidentiality: State and Federal laws limit confidentiality in situations in which there is a real or potential danger to you or others, when a court issues a subpoena or when child or vulnerable adult abuse or neglect is involved. There are other circumstances when information may be released including, but not limited to when disclosure is required by my licensing board (the Arizona Board of Behavioral Health Examiners), when a lawsuit is filed against me, to comply with worker compensation laws, to comply with the US Patriot Act, or to comply with other federal, state, or local laws. _____ initials

Coverage by Other Therapists: Occasionally when I am unavailable or out of town for an extended period, I may have another licensed therapist on call for me. I reserve the right to disclose confidential information from your records to this on-call therapist in order to facilitate coverage of your care in my absence. Any such therapist is bound by the same laws regarding confidentiality as am I. _____ initials

Electronic Tools: Please be aware that I utilize a number of electronic tools in my practice: computers, the Internet, e-mail, voice mail, and telephone. I will utilize reasonable back-up, security, and other safeguards to protect your information. However, there is always some risk of inadvertent disclosure of information that comes with using such tools. _____ initials

Consultation: Consultation is a process in which selected cases are discussed in order to facilitate my continued professional growth and to get you the benefit of a variety of professional experts. The dynamics of the problems and the people are discussed along with treatment approaches and methods. In consultation, I try to avoid specific identifying information about clients such as names. In some situations, I may ask an expert to review your clinical record. In such cases, the expert is bound by the same laws regarding

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confidentiality as am I. By signing this document, you acknowledge that you have an understanding that I may use your “case” for consultation purposes. If you have any questions regarding this topic, please feel free to discuss them with me. _____ initials

Records

The laws and standards of my profession require that I keep treatment records for six years. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. If you request to obtain your records/summary or request them to be given to a third party, you must sign an Authorization to Release Information. I will not video and/or audio record any of our session without your written consent. By initialing and signing this document, you also agree to not video and/or audio record without my consent as well.

Because they are professional records, they can be misinterpreted by untrained readers Therefore, it is highly suggested that initially we review them together or they be sent to another mental health professional so that you can discuss them with that professional.

In the event of my death, retirement, or incapacity, the clinical records for my clients who are actively receiving services (seen within the past month) will be given to Solace Psychological Services/Dr. Shannon Sticken to facilitate the continuation of treatment. In such a situation, you may choose to continue treatment with a therapist at Solace Psychological Services, discontinue treatment, or ask for a referral. Records for my inactive clients will be handled by Solace Psychological Services as well, which will be responsible for satisfying records requests and destroying records when the legal time frames for records retention are satisfied. _____ initials

Release of Records: Under the Administrative Code R4-6-1105(E) and my AAMFT Ethic Code, both partners must provide their consent to release marital/couples counseling records. This is true if one or either partner makes the request for a copy of the couples therapy record for themselves. If one or the other partner does not provide consent, records will not be released. _____ initials

Treatment Decisions

Participation in Treatment Decisions: Our first 3-5 sessions will involve evaluating your needs and clarifying the goals of your treatment. We will then develop a written treatment plan that will outline our agreed upon goals for treatment, and the methods of treatment. We will review the treatment plan as needed (minimally once per year, per Arizona statute) to ensure that we are meeting your treatment needs. The treatment plan will be revised as needed to reflect changes in our goals and treatment records. You have the right and obligation to participate in treatment decisions and in the development and periodic review and revisions of your treatment plan. _____ initials

Right to Refuse or Withdraw Consent to Treatment: Your treatment with me is optional and you are free to limit or end treatment at any time. In general, there will be no consequences to refusing or withdrawing consent to treatment. However, refusal to engage in recommended treatment may lead to a situation in which I am not able to help you because of the kind of problem you have or because my training and skills are not appropriate. Should this occur, I will inform you of this fact and refer you to another therapist who may better meet your needs. _____ initials

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Professional Fees

Fees for therapy are determined by the length of the session. A 50-60 minute session is \$225. **Payment is due at the time the service is rendered.** There are no refunds. Other services that will be billed at \$225/hour include report writing, telephone calls lasting longer than 15 minutes, attendance at meetings with other professionals which you have authorized, travel, and other expenses incurred. Any therapy which you and I have agreed in advance is necessary to conduct telephonically or via Skype will be billed at the same rates as face-to-face therapy and must be paid in advance of the session.

It is understood that the purpose of marital/couples therapy is for the reduction of distress within a relationship. Therefore, if you both request my services as a Marriage and Family Therapist, you each agree to refrain from using information provided to me during the therapy process against the other party in a judicial setting of any kind: civil, criminal, or circuit. Likewise, neither party shall for any reason attempt to subpoena my testimony or my records to be presented in a deposition or court hearing of any kind for any reason. Should I be court ordered to serve as a witness of fact, I will charge \$360/hour, including travel time. I reserve the right to change my fees with a 30-day notice. _____ initials

Insurance Reimbursement

Payment is due at the time of service. I do not accept insurance assignments or bill any insurance companies. If you choose to attempt reimbursement by your insurance company, it is therefore your responsibility to know what mental health services your insurance policy covers. If you plan to submit for reimbursement on your own, you may discuss with me a diagnostic code and/or superbill, which may be required by your insurance company. _____ initials

Contacting Me

I am often not immediately available by telephone as I may be with another client or out of the office. When I am unavailable, my telephone is answered by voice mail that I frequently monitor. I will make every effort to return your call within one business day.

Contact with me via e-mail is for the purpose of scheduling and confirming dates and times of appointments only. I do not give advice or provide therapy via e-mail. There are no exceptions to this policy. If you contact me in this way, I will suggest that you schedule an appointment. If you choose to communicate information to me via e-mail, I will assume that you have made an informed decision and I will view it as your agreement to take the risk that the communication may be intercepted. In the event of a crisis, you should call the Community-Wide Crisis Line at 520-622-6000. In the event of a life-threatening emergency, immediately call 911 or go to the nearest emergency room. _____ initials

Meeting Times

Regular attendance at your scheduled appointments is important for a successful outcome in therapy. Once an appointment is scheduled, you will be expected to pay for the session unless you provide 24 hours advance

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notice of the cancellation. If there are frequent cancellations, I may charge your credit/debit card directly. If you have repeated late cancellations or missed appointments, ultimately your treatment may be terminated.

Appointment availability varies with my client load. I reserve the right to limit my commitments of high-demand appointment times to any particular client in order to meet the needs of all my clients and to balance my workload. _____ initials

Our Relationship

The client/therapist relationship is unique in that it is exclusively therapeutic. It is inappropriate for a client and therapist to spend time together socially, to bestow gifts, or to attend family or religious functions, even after therapy ends. The purpose of these boundaries is to ensure that you and I are clear in our roles for your treatment and that your confidentiality is maintained. The initial 3-5 sessions are not only for assessment and development of treatment goals but also to determine if the clients and therapist are a good fit in terms not only of treatment and expertise, but also personality.

Should there ever be a time that you believe that I have treated you unfairly or disrespectfully, please talk with me about it. I want to address any issues that might get in the way of therapy as soon as possible. This includes administrative or financial issues as well as clinical issues.

In the event that I do not have contact or communication from the client(s) for a period of 90 days, I will consider that you no longer intend to remain active in your treatment with me. As a result, the Consent to Treatment will automatically expire and your clinical file will be closed. At that time, I am no longer considered your treating therapist of record. If you would like to continue treatment at a later date, please contact me to discuss this further. _____ initials

Consent for Evaluation and Treatment

Consent is hereby given for evaluation and treatment under the terms described in this consent document. It is agreed that either of us may discontinue evaluation or treatment at any time and that you are free to accept or reject the treatment provided. You attest that you have read the HIPAA NOTICE of PRIVACY PRACTICES (provided separately), and have had your questions about privacy and confidentiality answered to your satisfaction and additionally that you have had the opportunity to ask questions about any information provided in this consent document. The HIPAA NOTICE of PRIVACY PRACTICES is incorporated by reference into this document.

Signature: _____

Date: _____

Signature: _____

Date: _____

For Office Use only

Verification that client has read and understands the Informed Consent for Individual Psychotherapy and the HIPAA Privacy Notice

Therapist Signature: _____

Date: _____