

Informed Consent

Part I: Your Rights as Client(s)

1. You have the right to ask questions about any procedure used during therapy, if you wish; I will explain my approach and methods to you. If I see a child under the age of consent (which varies for different states/jurisdictions), all custodial parents have a right to information shared in the session. Custodial parents should be aware that exercising this right may be detrimental to the therapeutic process, and so may wish to allow confidentiality between the child and therapist.
2. You have the right to decide not to receive therapeutic assistance from me; if you wish, I will provide you with the names of other qualified professionals whose services you might prefer at a cost equal to or less than my own usual customary fee.
3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. I ask that you contact me by phone if you make such a decision without consulting with me.
4. You have a right to review your records in the files at anytime. I do not keep any "secret notes", so please do not ask me to do so.
5. One of the most important rights involves **confidentiality**; within limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. Additionally, when more than one family member is being seen in therapy, the therapist views the family as a whole as the client. Therefore, releases of information for family sessions require the written approval of every consenting member of the family who was present at any time during the treatment.
6. If you request it, any part of your record in the files can be released to any person or agency you designate. I will tell you at the time whether or not I think releasing the information in question to that person or agency might be harmful in any way to you.
7. You should also know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required to inform you of my actions in this regard. These situations are as follows: (a) if you threaten grave or bodily harm or death to another person, I am required by law to report to the local police department; (b) If a court of law issues a legitimate court order (signed by a judge), I am required by law to provide the information specifically described in that order; (c) If you reveal information relative to child abuse, child neglect, or elder abuse, I am required by law to report this to the appropriate authority; (d) If you are in therapy by order of law, the results of the treatment ordered must be revealed to the court; and (e) If you are seeking payment through an insurance company, I will be required to reveal confidential information to them (each insurer is different).
8. You have the right to know about the possible harmful results of therapy. In my years of psychotherapeutic service delivery and supervision, the only clear harm I have witnessed has resulted from clients' insistence on using medical insurance for psychotherapy. Harmful events included: denial of insurability when applying for medical and disability insurance due to DSM-IV-TR diagnosis (mental illness diagnoses, which are usually required for reimbursements under medical insurance); company (mis)control of information when claims are processed; loss of confidentiality due to the large number of persons handling claims; loss of employment, and repercussions of diagnosis in situations which require truthfulness about "mental illness", including driver's licenses applications, concealed weapon permits, and job applications.

Part II: The Therapeutic Process

Therapy will seek to meet goals established by all persons involved, usually revolving around a specific presenting problem. A major benefit that may be gained from participating in therapy includes a better ability to handle or cope with marital, family, and other interpersonal relationships. Another possible benefit may be a greater understanding of family and personal goals and values; that may lead to a greater maturity and happiness as individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy.

In working to achieve these potential benefits; however, therapy will require that firm efforts be made to change and may involve the experiencing of significant discomfort. Therapeutically resolving unpleasant events and relationship patterns can arouse intense feelings. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes that may not be originally intended.

Part III: Fees and Length of Therapy

1. *I agree to enter into therapy with Valentine Counseling Services. I agree to pay \$_____ for each session.*
 - a. *Payment is due at the beginning of each session, and no balance will be carried.*
2. *I understand that I can leave therapy at any time and that I have no moral, legal, or financial obligation to complete the maximum number of sessions listed in this contract; I am contracting only to pay for completed therapy sessions.*
3. *A 24 hour notice is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay the full session fee. I understand that this will be my responsibility.*
4. *I understand that the therapist has the right to seek legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.*

Client(s): _____

Date: _____

Therapist: _____

Date: _____

Your Rights as a Client:

1. You are entitled to information about any procedures, methods of therapy, techniques, and possible duration of therapy. If you desire, I will explain my usual approach as well as qualifications.
2. You have the right to decide not to receive therapeutic assistance from me or to seek a second opinion from another therapist. I will provide you with the names of other qualified professionals whose services you might prefer.
3. You have the right to end therapy at any time without any moral, legal, or financial obligation other than those already accrued.
4. In a professional relationship, such as ours, sexual intimacy between therapist and client is never appropriate. If sexual intimacy occurs, it should be reported to the **Minnesota Board of Marriage and Family Therapy, 2829 University Avenue, Suite 330, Minneapolis, MN 55414, 612-617-2220.**
5. You have the right to expect confidentiality within the limits described under #7 below.
6. If you request in writing, any records can be released to any person or agency you designate (note that consent from all clients in the treatment unit is needed for a release of records). Also, you may authorize me, in writing, to consult with another professional about your therapy.
7. There are certain situations in which I am required by law to reveal information obtained during therapy without your permission. These situations are: (a) if you threaten bodily harm or death to yourself or another person; (b) if a court of law issues a legitimate court order (signed by a judge); (c) if you reveal information relative to physical abuse, sexual abuse, or neglect of a child (in the past as well as the present); (d) if you are in therapy by order of a court of law, or, (e) if you are involved in a criminal or delinquency proceeding.

Consent to Treatment:

I affirm that prior to becoming a client of Valentine Counseling Services, she gave me sufficient information to understand the nature of therapy, including the possible risks and benefits of therapy, and the nature of confidentiality. I consent to participate in evaluation and treatment and I understand that I may refuse services at any time. I am also aware that the therapist will periodically consult with clinical supervisors, as required, on client issues. My signature below affirms my informed and voluntary consent to receive therapy. With the understanding of the above information and conditions, I agree to participate in therapy.

Client Signature(s): _____ Date: _____

Therapist's Signature: _____ Date: _____

IT IS CUSTOMARY TO PAY YOUR THERAPIST AT THE BEGINNING OF EACH SESSION.

- A Counseling Session is normally 50 minutes.

POLICY

A 24 HOUR CANCELLATION NOTICE IS APPRECIATED; OTHERWISE USUAL FEE WILL BE CHARGED.

I understand that suicidal threats, homicidal threats or child abuse by an adult to a child will be reported.

I understand and give permission to my therapist to seek clinical supervision or consultation about my situation when necessary.

Client Signature: _____ Date: _____