

## **Informed Consent for Therapy**

**General Information:** I feel honored that you have chosen to work with me for your counseling needs. I aim to provide a safe, private, and comfortable atmosphere that will facilitate us reaching the goals for therapy we have determined together. It is important that you are knowledgeable about how our relationship will work most effectively. Please take a few minutes to review the following information and let me know if anything is unclear or if you have any questions.

I am a Licensed Mental Health Counselor with a Masters in Clinical Mental Health Counseling. I am certified in both EMDR (Eye Movement Desensitization and Reprocessing) and Trauma Model Therapy (TMT). I have also been trained in ACT (Acceptance and Commitment Therapy) and DBT (Dialectical and Behavioral Therapy). I am currently a Consultant in Training through EMDRIA. I abide by the code of ethics as determined by the Florida State Legislature and American Counseling Association guidelines. Upon request, a copy of these ethical guidelines will be provided to you.

I view the client as the expert of his/his/their life and believe that the therapy process is a cooperative effort between client and therapist- and parent(s)/guardian(s) if applicable. The level of success of your therapy will be dependent upon your level of willingness to be honest about your experience, including thoughts, feelings, and behaviors. When we attempt to address and heal from painful or difficult experiences or concerns, the work we do may be an uncomfortable process that will need to proceed at a pace that is comfortable and safe for you. We will maintain open communication about your level of comfort. Careful consideration must be given as to whether any potential risks are worth the benefits to you. I commit to do what I can to help minimize risks and maximize positive outcomes for you. This may involve you being asked to complete work outside of our time together in the office, bringing in other family members, or you seeing your physician for a physical examination. You have the right to refuse anything that I suggest without being penalized in any way.

It is important for you to understand that I am not a medical doctor. Although we may discuss your medical condition(s) and your use of medical interventions, my comments are not intended to negate or replace the recommendations by your physician. Please know that you are always advised to follow your physician's instructions and guidelines until or unless you discuss possible revisions with him or her. Therapy is a relationship between people, which works in part because of clearly defined rights and responsibilities held by each party involved. As a client, you have certain rights that are important for you to know. There are also certain legal limitations to those rights that you should be aware of. As a therapist, I have responsibilities to make you aware of these rights.

**Confidentiality:** 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. Limitations of such client-held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to complete 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 the 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 or neglect of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. If a court of law issues a legitimate subpoena for information stated on the subpoena.
6. 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.

Occasionally I may consult with other professionals, including my consultants, peers, and consultees, in order to provide the best treatment for you and for educational purposes. Information about you may be shared in this context without using your name or other identifying information.

If we ever happen to see each other outside of the therapy office, I recognize it is your choice as to whether or not you would like to acknowledge me; therefore, I will not acknowledge you unless you first acknowledge me as I do not wish to jeopardize your privacy. If you choose to engage, I will be happy to speak briefly with you but feel it appropriate not to engage in lengthy discussions in public or outside of the therapy office in order to protect our therapeutic relationship.

For children's, couples, or family treatment, all of the terms set forth here and in the adjunctive documents mentioned here apply to all participants in the treatment. For these types of treatments, you understand that I will not keep secrets from any individual in that treatment.

**Records and Release of Records:** I will keep a written record of your therapy for seven years at my office. Your entire file is confidential and will be maintained for seven years following termination of therapy as required by law. If requested in writing, information in any part of your record can be released to you, or to a person or agency you designate in writing. Florida law allows me to send a report or summary of the therapy in lieu of the full record if I believe that is necessary and beneficial to you. I cannot release records to a third party unless every person that has taken part in the session(s) agrees to sign the release.

**Financial Arrangements and Insurance:** Payment for services are due at the time of service unless arrangements have been made in advance. I am not currently an in-network provider for any insurance panels but can provide a superbill for possible reimbursement. There are many advantages to paying out of pocket. Insurance companies require diagnoses that may become part of your permanent medical record. Insurance companies may cite these diagnosis/es as reason/s to deny coverage to you

in the future. Insurance companies can also dictate the type of therapy and length of service, potentially limiting the work we do together. It is my opinion that the course of therapy is best determined as a collaborative discussion between therapist and client(s), and do not want your therapeutic needs dictated by insurance. If it is necessary for you to find a counselor that can utilize your insurance benefits, I will be happy to provide a referral source.

I re-evaluate my budget and fee structure annually. Factors such as overhead expenses and continuing education/training expenses may necessitate a change in my fees. You will be notified in writing and in session in advance of any change to my fees. Cash, checks, Zelle, Venmo, and credit cards are accepted forms of payment.

**Out of Session Communication:** If you need to contact me between sessions, you may leave a message on my voicemail or email me. I may not be immediately available; however, I will attempt to return your call within 24 business hours. Please note that face to-face conversations are highly preferable to a phone discussion if possible. However, if an emergency situation arises, and I am not immediately available, please call **Life Line of Central Florida 407-425-2624**, go to the nearest emergency room, or call the police for immediate assistance. You may occasionally find it necessary to ask for a consultation on the phone. I reserve the right to bill for these services if it is a lengthy call (lasts more than 15 minutes) or occurs frequently.

**Social Media and Telecommunication:** Due to the importance of your confidentiality and of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any personal social networking site, but you are welcome to join the Mosaics social media accounts. I believe that adding clients as friends or personal contacts on these sites can compromise your confidentiality and our respective privacy and may also blur the boundaries of our therapeutic relationship.

**Electronic Communication:** I cannot ensure the confidentiality of any form of communication through electronic media, including emails or text messages. You may choose to communicate via email/text for issues regarding scheduling or cancellations. While I will try to return messages in a timely manner, I cannot guarantee an immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. If there are boundary or safety challenges that arise due to electronic communication, it will be discussed in session.

**Minors:** If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

**Termination:** The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process

if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to work with you. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for sixty consecutive days, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued. If you wish to reinstate services, every effort will be made to accommodate returning clients. Fees will be updated to the current standard charges.

If you have any questions or concerns, please feel free to bring them up with me. I truly consider it a privilege to partner with you in helping you reach your therapeutic goals and move toward healing and wholeness.

Your signature(s) indicate that you have read and agree to the above policies and give your consent for me to do counseling with you and/or your family. It is necessary that each person receiving treatment, over the age of 14, sign below indicating an understanding and agreement.

This is to certify that I have read the above information and that I consent to psychotherapy treatment. Upon request, Amanda Martin will make a copy for you to keep. HIPAA requires that a completed copy be maintained in your chart acknowledging that you are giving your consent to participate in therapy and that you have seen my office policies.

_____ Client Signature	_____ Client Printed Name	_____ Date
_____ Client Signature	_____ Client Printed Name	_____ Date
_____ Client Legal Guardian (if applicable)	_____ Client Legal Guardian Printed Name	_____ Date
_____ Therapist Signature	_____ Therapist Printed Name	_____ Date