

InSight Psychology and Behavioral Health Services LLC

Informed Consent for Therapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by hand written or electronic signature.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy for yourself (and/or your child). The outcome of treatment depends largely on your (or your child's) willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior (or your child's behavior) or circumstance will change. I can promise to support you (and/or your child) and do my very best to understand you (and/or your child) and repeating patterns, as well as to help you clarify what it is that you want for yourself (or what your child may need to resolve problems).

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client (or client's parent or legal guardian) 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 commit 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 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. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. 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 need to consult with other professionals in their areas of expertise in order to provide the best treatment for you (or your child). Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you (or your child) acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Acknowledgement/Awareness of Safety Protocol

If you display a weapon (e.g., knife/gun etc.) or threaten harm either directly, in jest or indirectly on the premises of InSight

Psychology and Behavioral Health Services LLC, it is considered a threat to safety. This is grounds for immediate termination of all treatment services.

If patient is a minor (below the age of 18) this form must be signed by parent, legal guardian or legal conservator.

Name of Client :

Date of Birth:

Name of Parent/Legal guardian/Conservator if client is a minor.:

Hand Written Signature _____ **Date** _____

If form is signed electronically, signature will show below.