Informed Consent for Treatment

The following information is being provided as an effort to inform clients about the treatment process and counseling relationship as required by the Texas Board of Examiners of Marriage and Family Therapist in order to protect the public. If you have questions regarding any of the following information, please discuss them before signing.

Counseling Relationship: The relationship that exists between a therapist and a client is professional rather than social. Therefore, contact will consistently occur in the context of the provision of professional service. In the case that meeting in public is unavoidable, client confidentiality will be protected and interaction **will only take place if the client indicates that this is permissible. _____**Initial

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling services. While benefits are expected from counseling, specific results are not guaranteed. **It is extremely important to notify your therapist, as soon as possible, of new information that may have an impact on the success of therapy. _____**Initial

Client Rights and Responsibilities: The length of time needed for healing and the amount of intervention required varies with each individual, couple or family. The client has the right and responsibility to be involved in the treatment plan which will be discussed on a regular basis. As the client, you are in complete control and may end the counseling relationship at any time; however, **participation in a termination session is requested. Failure to contact the therapist for a three month period will result in automatic termination. _____**Initial

Cancellations: Counseling services are by appointment only. The client is responsible for keeping appointments and arriving on time. 24 hour notification of cancellation is required to avoid service fee. Rescheduling missed appointments is the responsibility of the client. **Three "no shows" may result in termination of counseling relationship. _____**Initial

Referrals: In order to assist in the recovery needs of your family, it may be necessary to refer to other mental health professionals or agencies. It is important to consider the referral recommendation as it may affect the ability for counseling

services to continue. As your therapist, I will provide you with some alternatives including programs/and or people who may be available to assist you. **You will be responsible for contacting and evaluating these referrals. _____**Initial

Fees: The fee for a 50 minute session is $110 and is due when services are rendered. Accepted payment forms include cash, check, Visa, Master Card, Discover, and PayPal. Please discuss the possibility of filing sessions with your insurance provider with the clinician. _____Initial

Confidentiality: Confidentiality is described as keeping private information between a client and therapist. Therapy sessions are strictly confidential. However, in the event of a court order, all clinical records can be subpoenaed. The following are also possible situations that may limit confidentiality: a) concerns that a client is a danger to himself/herself or others; b) the disclosure of abuse, neglect, or exploitation of a child, elderly, or disabled person; c) the disclosure of sexual misconduct or unethical behavior of another mental health professional; d) the client orders the disclosure of the information. In reference to the treatment of minors, risk-taking behavior that is considered detrimental to the safety of the minor or others will be shared with the minor's parent or guardian. _____Initial

Additional Matters: In the event of my death or incapacitation, or I close my office, my files will be retained by Dr. Jan Dunn LMFT for up to five years after your last appointment date.

Because email/texting is not a secure or confidential medium, I cannot guarantee that any email/text that you may send to me will remain confidential. I do consider your communications private and do all I can to maintain confidentiality. If you choose to email/text me, include a phone number where I may reach you if a reply is requested. I do not monitor email/text messages continuously; so the most effective way to reach me is via phone. **EMAIL/TEXTING IS NOT RECOMMENDED AS A METHOD FOR CONTACTING ME IN AN EMERGENCY**. Please note that if you choose to email/text me and I decide to respond, I will respond to the address/phone number from which it is sent. _____Initial

I have read and understand the above information and agree to voluntarily enter myself and/ or my dependents in the counseling services provided by Elise Thompson, LMFT. I further understand the limits of confidentiality and understand that those limits also apply in the case of a minor. If I am the legal conservator or guardian of a minor, my signature below indicates my consent to their treatment.

Acknowledgements

_____	_____
Client Signature	Date
_____	_____
Guardian Signature if applicable	Date
_____	_____
Therapist Signature	Date