

INFORMED CONSENT FOR TREATMENT

_____ authorizes and requests **Anita Cooper-Marquez, LMFT** to provide screening, assessment, diagnostic procedures, treatment planning, and interventions that are developed collaboratively between therapist and client. Records of sessions are kept as required by law and professional standards.

Treatment is provided in a dog friendly environment. If this creates any concern for you, please discuss this prior to or during the first session. Appointments are usually 50-55 minutes in length and are usually scheduled weekly on a regular basis until the majority of goals have been met. At that time other arrangements may be discussed. If an appointment needs to be cancelled, 24-hour notice is required so the time can be available for someone else. Cancellations without 24-hours notice will incur a charge, with exceptions made for true emergency situations or if the insurance carrier prohibits.

Therapy involves both benefits and risks. Risks include the possibility of experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, and helplessness. Therapy often requires recalling experiences, some of which may be unpleasant. Should you notice any negative effects, please let me know. Therapy has been shown to have benefits for those who wholeheartedly participate. It often leads to reduced feelings of distress, better relationships, and resolution of specific problems. It is understood that there is an expectation that the client will benefit from treatment, however there is no guarantee this will occur. It is understood that maximum benefit will occur with consistent attendance, and at times the client may feel conflicted about therapy as the process can sometimes be uncomfortable. When working with couples or families, Anita will not be the “keeper of secrets”. All topics will be encouraged to be discussed openly and honestly.

CONFIDENTIALITY: All information disclosed within sessions, including those with minors, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:

- When there is a reasonable suspicion of abuse to a child, dependent adult or elder adult
- When there is a reasonable suspicion of knowingly downloading, streaming and accessing through electronic or digital media, materials of a child engaged in an act of obscene sexual conduct.

- When there is a reasonable belief the client may be a danger to him or herself, others, or property of others.
- When disclosure is otherwise required by law.

EMERGENCY TREATMENT: If you have a life threatening emergency, please call 9-1-1. **Anita** is not able to provide availability 24-hours/day. Calls are typically returned within the next business day.

PAYMENT: Payment is expected at each session and **cannot** be made in advance (this may include a copay if insurance is used). Unless otherwise agreed upon, the fee is \$100 per individual session and \$150 per couples or family session (family session fee may increase dependent upon the number of members participating). You are responsible for payment of all services rendered, including if your insurance carrier refuses to pay. If payment is made by check, there will be a \$15 service charge for all checks returned by the bank. If payment is made by credit card a 5% fee will be charged in addition to the session fee.

THERAPEUTIC TOUCH: On occasion Anita may use therapeutic touch during therapy sessions. The touch is meant to provide a grounding touch of the hand. It is understood that therapeutic touch and the client-therapist relationship is *always* non-sexual in nature.

TELEPHONE, TEXT, AND EMAIL: Please reserve discussing problems that arise between sessions for the next scheduled appointment. Unless there is an emergency, schedules do not permit me to talk on the phone, respond to lengthy texts, or answer lengthy emails between sessions. If you feel the need to text or email information beyond the routine scheduling of appointments, we will wait to discuss the content in our next session. If telephone calls are necessary for a client emergency, please schedule a time for a telephone consultation, which will be charged at our regular rate in 15-minute segments. Please do not electronically send anything of a confidential nature as this may not provide the privacy necessary for HIPAA compliance. Voicemail can be reached 24 hours per day 7 days per week. (All of the above is subject to approval by the insurance carrier if insurance is being used).

DIAGNOSIS: It is important that you understand that I am not a physician, therefore no diagnosis from me is a judgment about any **physical** condition. Working with me should

never be considered a substitute for a thorough medical evaluation. A complete physical is recommended at minimum every two years.

TERMINATION OF THERAPY SERVICES: Termination may be discussed/considered if:

- I do not believe I can provide you with effective treatment
- Your needs are outside the scope of my experience or training
- There is drug/alcohol use on the day of the session that I believe hinders therapy
- You desire to terminate treatment or it is mutually agreed upon
- A conflict of interest develops
- You or I believe it is in your best interest

If you and I decide to terminate therapy services, I recommend at least one closing session.

ACKNOWLEDGEMENT AND AGREEMENT FOR INFORMED CONSENT

I have read and fully understand this consent for treatment form.

Client **Signature/Date**

Therapist **Signature/Date**

Client **Signature/Date**