Hope for Healing Counseling, LLC. 11225 North 28th Drive Suite A210, Phoenix, AZ 85029. 602-883-3646

**Informed Consent for Psychotherapy**

1. 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 filling in the checkbox at the end of this document.

The Therapeutic Process: You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your 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 circumstance will change. I can promise to support you and do my very best to understand you and any repeating patterns of behavior, as well as to help you clarify what it is that you want for yourself.

1. Counseling Agreement/Client Rights
   1. It is agreed that the client shall make a good-faith effort at personal growth and engage in the counseling process as an important priority at this time in their life. When assignments are given please understand these are instructive and prescriptive: meant to support the client in between office visits. Client gain is most important in professional counseling.
   2. The therapist reserves the right to make a clinical decision regarding what is in the best interest of the client and the therapeutic relationship regarding: suspension of sessions, termination of counseling and/or referral to another therapist. Such issues shall be discussed between counselor and client in regard to a pattern of behavior showing disinterest or lack of commitment, frequent or multiple cancellations or for any unresolved conflict or impasse between counselor and client.
   3. The client reserves the right to refuse any recommended treatment or withdraw from treatment at any time. The preference is that the client discuss these intentions with the therapist.
   4. The client has the right to participate and self-determine and make their own choices within the context of therapy. For example, if a particular therapy is recommended but after explanation of the therapy, the patient does not prefer it, this is the patient’s right to decline this form of therapy.
   5. The client has the right to be informed of the risks and benefits of therapy: The client needs to be aware that the benefits of counseling and talk-therapy may include such benefits as having confidential access to a health care professional who has training in mental health, support, developing skill sets to cope mentally and emotionally with personal issues, the ability to function better at home or school, communicate more effectively with others, repair or restore difficult relationships with family, friends and co-workers. Potential risks include the possibility of emotions being difficult to manage as one begins the process of sharing information that is highly emotionally sensitive or painful. In some cases, symptoms of depression or anxiety may exacerbate somewhat as one enters the therapeutic process of counseling.
   6. Effective therapy is often facilitated when the therapist gathers within the session, or a series of sessions, a multitude of observations, information and experiences about the client. Therapists make clinical assessments, diagnosis and interventions based on direct auditory, visual and olfactory observations of clinically or therapeutic relevance based on what they see and hear from you in the counseling sessions.
   7. TREATMENT PLAN: We will create a treatment plan together in your first or second session that will list your objectives for therapy and how we will approach the concerns you have in therapy. This “roadmap” will be discussed with you periodically and you will be invited to sign the treatment plan both at the beginning of therapy and when updates are made.
2. Confidentiality:

This office follows the HIPAA guidelines for confidentiality and the protection of the counseling record. Therefore, all therapeutic communications, records, and contacts with professional and support staff will be held in strict confidence. Information may be released, in accordance with State law and clinical ethics.

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 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.
8. EAP, Worker’s Compensation, and other insurance utilization provisions may apply. It is the client’s responsibility to ask/know their requirements and benefits in these situations.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

I utilize an outside billing service to assist in collection of insurance payments and co-payments. At times the staff associated with the billing service may need to access demographic and financial data to complete their work.

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 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.

1. Initial Assessment/Evaluation Sessions: The client agrees that the first session is intentionally an assessment session and is charged at a higher rate due to the extended period of time necessary for initial intake assessments and does not commit the therapist (or the client) to ongoing therapy with the client. If for any reason, as a result of the intake assessment session, the therapist deems counseling with the client not to be appropriate with this therapist, the therapist may choose to terminate continued therapy and refer the client elsewhere. The client also has the right to withdraw from counseling at this time for any reason.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_