Treatment Agreement:

I am pleased that you have selected me as your counselor. This document is designed to inform you about my background and to ensure that you understand our professional relationship. I am licensed in the state of Arizona as professional counselor. My counseling practice is limited to individuals, couples and relationships. I hold a master's degree in counseling psychology from New York University. I only accept clients into my practice that I believe have the capacity to resolve their own problems with my assistance. I believe that as people become more accepting of themselves, they are more capable of finding happiness and contentment in their lives. However, self-awareness and self-acceptance are goals that sometimes take a long time to achieve. Some clients need only a few sessions to achieve these counseling goals, while others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any point. I will be supportive of that decision. If counseling is successful, you should feel that you are able to face life's challenges in the future without my support or intervention. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that counseling will yield positive or intended results.

Although our sessions may be very intimate emotionally and psychologically, it is important for you to realize that we have a professional relationship rather than a personal one. Our contact will be limited to the paid sessions that you have with me. Please do not invite me to social gatherings, offer gifts or ask me to refer to you in any way other than in the professional context of counseling sessions. You will best be served if our relationship remains strictly professional and if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me only in my professional role. In the event that our paths cross in social or public settings, our therapeutic relationship comes first. In order to protect your confidentiality, I will not initiate a greeting.

Confidentiality

All of our sessions are kept confidential. No information will be released without the client's consent unless mandated by law. I am required by law to disclose confidential information to the appropriate authorities when; 1) the therapist hears of or suspects child abuse, elder abuse, or dependent adult abuse, 2) the client is thought to be in danger of harming him/her self, 3) when the client threatens serious harm to someone else or 4) when required by court order.

Sessions

Counseling sessions are between 50 and 90 minutes long. Please respect this time limit. If you are late, your session will still end at the normal time. My policy requires a 24-hour cancellation notice. Unless 24 hours notice is given you will be charged your regular session fee. Please refrain from drinking alcohol or using drugs that would cause you to be intoxicated at the time of your session. If the therapist suspects the client is under the influence of drugs or alcohol, the session will be terminated immediately and billed as a missed appointment.

Fees and Payment

Payment for initial intake and assessment is $150 for a 50-60 minute session. Payment thereafter for individual session (phone, skype or in person contact) is $150 for a 50-60 minute session. Couples counseling is $200 for a 50-60 minute session. The fee for each session will be due and must be paid at the time of services. Cash, credit or personal checks are acceptable forms of payment.

Insurance

Some insurance companies will reimburse clients for counseling services and some will not. Most will require that I diagnose your mental-health condition before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis I plan to render before I inform your health insurance company. Any diagnosis will become part of your permanent insurance record. Please see the Arizona "HIPAA" form that I have provided you.

Insurance Continued

If you wish to seek reimbursement for my services from your health insurance company, I will be happy to complete any forms that are related to your reimbursement provided by you or the insurance company. Because you will be paying me each session for my services, any later reimbursement by the insurance company will be sent directly to you. Please do not assign any payments to me. Those insurance companies that usually reimburse for counselors usually require that a standard amount be paid ("a deductible") by you before reimbursement is allowed, and then usually a percentage of my fee is reimbursable. You should contact your insurance company representative to determine whether your insurance company will reimburse you and what schedule of reimbursement is used. Comprehensive Billing Services LLC takes care of billing your claims to the insurance. They are held to the same HIPAA laws as my office. If you have questions about your insurance you may contact them directly at 480-204-2477.

Telephone Contact and Emergency Procedures

If you need to contact me between sessions, please leave a message on my voicemail at 602-321-9536 and your call will be returned as soon as possible. I check messages a few times a day, unless I am out of town or otherwise preoccupied. If an urgent situation arises, please indicate it clearly in your message. If you need to talk to someone right away (an emergency), call the National Hopeline Network (24-hour crisis hotline) at (800) 784-2433 or the police (911).

Electronics

I grant consent for my counselor: James Kelleher, to correspond with me via email and/or text messaging for the purpose of scheduling appointments or conveying general information about my care or the services. I understand that email/texts are not a secure form of communication and that confidentiality of any emailed/texted information cannot be ensured. Please be advised that email/text are not to be used in order to communicate urgent matters or emergencies. I understand that I may revoke this authorization at any time by writing to James Kelleher, except to the extent that action has already been taken to send the email/text information. I also understand that while precautionary measures are in place there is no guarantee with communication that involves fax machines, internet and other modes of electronic devices. My signature indicates that I understand the risks involved with electronic communication (ie email/text messaging) and that confidentiality cannot be guaranteed.

Termination

An orderly end of therapy has positive effects for clients. It is *suggested* that you discuss openly with me your wish to end therapy at least three sessions prior to your last session. A final closure session has proved to be very important for clients. Closure sessions help you acknowledge and summarize what you have accomplished and discuss any unfinished concerns you may have. While not required they are strongly recommended.

Notice of Privacy Practices (HIPAA)

Signing this document means I have read the NPP and have been made aware of how my medical records may be used and disclosed.

_____

Client signature date _____/_____/_____

_____

Client signature date _____/_____/_____

_____

Therapist signature date _____/_____/_____

EMDR CONSENT FORM

Eye Movement Desensitization and Reprocessing (EMDR) methodology is a form of adaptive information processing when may help the brain unblock maladaptive material. I have been advised and understand that EMDR is a treatment approach that has been widely validated by research on PTSD. Some studies indicate that EMDR is also effective in reducing anxiety and other symptoms.
I have also been specifically advised of the following:

a) Distressing unresolved memories may be surface through the use of the EMDR procedure.

b) Some clients experience reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including but not limited to the high level of emotional or physical sensations, disorientation, fear or nausea.

c) Subsequent to the treatment session, the processing of incidents/material may continue and dreams, memories, flashbacks, feelings. etc... may surface.

d) Memory is imperfect and research has shown that there is no guarantee that all information recovered during therapy, unless it can be corroborated is factually accurate. On the other hand, information which is so revealed may in fact be accurate. Similar to hypnosis, memories recalled via EMDR may be considered by courts to be invalid for use in any future legal actions.

My clinician has explained to me the reasons why the use of EMDR is recommended in my therapy or for my child and that there are other options available to me should I decide not to use EMDR and not to give my informed consent. The clinician has provided me with an explanation about the nature of EMDR and my questions about EMDR have been answered.

Before commencing EMDR treatment, I have considered all of the above and I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate to having EMDR treatment and by my signature below I hereby consent to participating in EMDR treatment. I understand that I may stop treatment at any time before or during any EMDR session and that more than one EMDR session is usually necessary in the treatment.

My signature on this acknowledgment and consent is free from pressure or intelligence from any person or entity and I agree to hold harmless my EMDR clinician for any unpleasant or unexpected effects which may arise from my experience or my child's experience with EMDR.

Client/ Guardian signature:_____Date:_____

Therapist signature:_____Date:_____