

# Informed Consent for Psychotherapy

## **General Information**

The therapeutic relationship is unique in that it is highly personal and at the same time, a contractual agreement. It is important for us to reach an 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 each of this disclaimer.

## **The Therapeutic Process**

You have taken a very proactive 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 ongoing feelings of anger, depression, anxiety, etc. There are no miracle cures; I cannot promise that your behavior or circumstances will change. I can promise to support you and do my absolute best to understand you and repeating patterns as well as to help you clarify what it is that you want for yourself.

The session content and all relevant material to your treatment will be held in strict confidential, unless you (as the client) request in writing to have any or all portions released to a specifically named person. There are four (4) limitations of each claim held privilege of confidentiality exist and are named below:

1. If the client threatens or attempts to commit suicide or otherwise conducts him/herself in any manner, where there is a risk of suicide or serious bodily harm of occurring.
2. If the client threatens grave bodily harm or death to another person.
3. If the therapist has reasonable suspicion that the 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. Suspicion as stated above on a case of an elderly person who may be suspected to the previously mentioned abuses (see 3. above).

### **Client Rights**

- The right to be treated with dignity and respect at all times.
- The right to be involved in the planning and/or revision of their treatment plan.
- The right to know about my treatment progress or lack thereof.
- The right to reject the use of any therapeutic technique, and to ask questions at any time about the methods used.
- The right to be spoken to in a language that is fully understood.
- The right to a clean and safe environment.
- The right to refuse to be videotaped, audio recorded, or photographed.
- The right to end treatment at any time, unless court ordered.
- The right to file a complaint or grievance.
- The right to confidentiality of clinical records and personal information according to federal and state laws.

**I understand the fee of \$130 will be billed to my insurance company upon availability and confirmation of service. I understand I am responsible for my co-pay at the time of service, which is the amount dictated by my insurance plan.**

**I understand if I cancel my appointment in less than 24 hours of the scheduled appointment, I may be charged 25% of the session fee.**

### **Emergencies**

I understand I may reach my therapist provider at [217-370-8311]. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life-threatening emergency, I should call 911.

I have read, discussed, and understood all of the above.

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**Signature**

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**Date**