



Deedee Shaw LICSW
330 North 48th St, Suite A
Lincoln, NE 68504-3515
Phone 402-326-9168

INFORMED CONSENT FOR THERAPY

The therapeutic relationship is unique in that it is both highly personal and contractual. Given this, we need 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 intense 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 very best to understand you and your repeating patterns, as well as to help you clarify what you want for yourself.

CONFIDENTIALITY

The session content and all relevant materials to the client's treatment will be kept confidential, unless the client requests in writing that all or portions of such content be 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.



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INFORMED CONSENT FOR PSYCHOTHERAPY

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

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 compromise it. However, if you acknowledge me first, I will be more than happy to speak briefly with you. It is appropriate not to engage in any lengthy discussions in public or outside the therapy office.

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

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

Relationship to Patient _____

Witness Signature _____ Date _____