



Informed Consent for Psychotherapy Services

Welcome to Living Water Therapy. This document outlines important information about psychotherapy services and your rights as a client. Please read it carefully. If you have any questions, feel free to ask for more clarity.

Purpose and Process of Therapy: Psychotherapy is a collaborative process aimed at helping you achieve your personal goals, usually concerning a specific presenting problem, and improving your mental health in general. Some benefits of therapy include: 1) a better ability to handle or cope with marital, family, and other interpersonal relationships, 2) greater understanding of family and personal goals and values.

While therapy can be beneficial, it may involve discussing challenging emotions or experiences. Therapeutically resolving unpleasant events and relationship patterns can arouse intense feelings. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes that may not have been originally intended. Your participation is voluntary, and the outcome depends on various factors, including your active engagement in the process toward positive change. As such, we cannot offer any guarantees of a desirable outcome.

We use a systemic philosophy of psychotherapy which encompasses a variety of modalities, each tailored to different needs and therapeutic goals. Your therapy may include, but is not limited to, the use of one or several of the processes and techniques commonly used in the following modalities:

- **Cognitive Behavioral Therapy (CBT)** – Identify and change negative thought patterns and behaviors.
- **Psychodynamic Therapy** – Explores unconscious processes and past experiences to understand present behavior.
- **Internal Family Systems (IFS)** – Explores your own internal system of emotions and how to manage them.
- **Emotionally Focused Therapy (EFT)** – Explores how to trade negative interactions with deeply emotional encounters.
- **Eye Movement Integration (EMI)** – Primarily used for trauma; involves guided eye movements to process distressing memories.
- **Contextual or Structural Therapy** – Focuses on interpersonal relationships and interactions within family systems.
- **Solution-Focused Brief Therapy (SFBT)** – Concentrates on finding solutions rather than analyzing problems.
- **Gestalt Therapy** – Encourages awareness of the present moment and personal responsibility.
- **Gottman Method** – Focuses on building Love Maps between intimate partners.
- **Existential Therapy** – Explores meaning, freedom, and personal responsibility in life.
- **Judeo-Christian worldview** – as appropriate and with client approval, explore how faith informs human flourishing.

We are committed to fostering an inclusive environment where all individuals are treated with respect and dignity. Discrimination or harassment based on race, color, ethnicity, national origin, age, gender, gender identity, sexual orientation, disability, religion, or any other characteristic protected by law will not be tolerated. We uphold equal opportunities for all and strive to create a therapeutic space where diversity is valued.

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Confidentiality: Your privacy is important to us. Information you share during sessions will remain strictly confidential and not revealed to any other person or agency unless: 1) You provide written consent to disclose information to a person or agency you designate. Your therapist will discuss their thoughts of how such disclosure might be harmful in any way to you, 2) There is a risk of harm to yourself or others, 3) There is a reasonable suspicion of child abuse or neglect, 4) When more than one family member is involved in therapy, the therapist views the whole family as the client. Therefore, releases of information for family sessions require the written approval of every consenting member of the family who was present at any time during the therapeutic process, 5) We maintain a “No Secrets” policy when working with couples and families. If one member shares information which threatens the health of the relationship when others are not present, your therapist will not keep that information undisclosed but will facilitate your disclosure in a joint session, 6) Disclosure to other persons or agencies is required by law without client permission. I am not required to inform the client of any actions in this regard. These limits to confidentiality include: a) suspected abuse or neglect of a child, elderly person, or disabled person, b) clear indication that you are in danger of harming yourself or another person or if you are unable to care for yourself, c) a court order requires release of information, 7) Therapist seeks clinical supervision, sometimes with audio/video recording

Electronic Communication: Email has significant limitations and confidentiality cannot be guaranteed. It is important to be aware that computers, unencrypted email and texts can, with relative ease, be accessed by unauthorized people; hence compromising privacy and confidentiality of such communication. If you communicate confidential or private information via unencrypted email or texts, I will assume that you made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted. I will honor your desire to communicate these matters in this way.

Public Encounters and Social Media: Be aware that you and your therapist may encounter each other in a public space or through social media. Despite the circumstances, your therapist will not initiate contact with you in those spaces but will respond in kind when you choose to do so. Requests initiated by you to “friend” or “follow” will be ignored by your therapist. Your therapist will not pursue you either in public or on social media.

Litigation: I will not voluntarily participate in any litigation or custody dispute. I will not communicate with a client’s attorney and will not write or sign any letters, affidavits or reports to be used in a client’s legal matters. I will not provide testimony or client records unless compelled to do so by a court of law. Should I be subpoenaed to appear as a witness in an action involving a client, the client agrees to reimburse me for time spent for preparation, travel, court appearances, etc. at the hourly rate of \$400.

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Emergency Procedures: I am not available for emergencies. If you experience a mental health crisis, you can call **911** or go to your nearest hospital emergency room. You could also reach out to **988**, the National Suicide Prevention Lifeline, which provides free and confidential support 24/7. Additionally, here are some local resources in the Berks & Lancaster Counties area:

- **Berks County Mental Health** – (610) 478-3271
- **Tower Behavioral Health** – (484) 339-6037
- **Lancaster County Crisis Hotline** – (717) 394-2631

Insurance: At this time, I do not take insurance; however, you may submit your expenses for reimbursement from your insurance plan. Insurance claims and reimbursements are your responsibility. Contact the representative for your insurance plan to find out about your mental health benefits. I will provide a receipt containing the information typically required by insurance companies when filing claims.

Client Rights As a client, you have the right to:

- Ask questions about any procedures used during therapy. At your request, we will explain our approach and methods to you. If therapy is for a child under age 14, all custodial parents have a right to information that is shared in session. Custodial parents should be aware that exercising this right may be detrimental to the therapeutic process. For this reason, you may choose to allow confidentiality between the child and therapist.
- Decline specific treatments or interventions.
- Terminate therapy at any time without any moral, legal, or financial obligations other than those already accrued. Respectfully, we ask that you inform us of your decision to terminate.
- Be treated with respect and dignity in which discrimination or harassment based on race, color, ethnicity, national origin, age, gender, gender identity, sexual orientation, disability, religion, or any other characteristic protected by law will not be tolerated.
- Review your records which will be made available to you within 30 days of your written request. If you ask us to keep any “secret notes” in your file, we will not do so.
- Have a copy of this informed consent.

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Fees, Policies and Signature(s):

I/We, (Printed Name(s)) _____
have requested therapeutic services for myself/ourselves and/or the following persons for whom I/we have legal guardianship. _____.

- I/We understand that services will be provided by Master's Level Marriage and Family Therapists either fully licensed by the state of PA or pursuing licensure as per the rules and laws of PA. I/We also understand and give permission for the therapist to seek clinical supervision or consultation about my/our situation when necessary.
- I/We understand that a therapy session is normally **55 minutes in length**, and the fee will be **\$100 paid at the time of the session. You may pay with cash or personal check (bounced checks will incur additional charges to be determined). I/We understand that, except for emergencies, a 24-hour cancellation notice is required to avoid additional fees. Historically, most clients find a successful end to therapy after an average of eight (8) sessions.**
- I/We understand that Living Water Therapy may incorporate a Christian World View or Biblical component into our therapeutic services. I/we decline the use of this component in therapy sessions with my/our initials here _____.
- I/We understand that I/we can end therapy at any time without moral, legal, or financial obligation to complete any minimum or maximum number of sessions. I/we understand that when therapist decides to terminate, I/we will be referred to another therapist.
- I/We give permission for Living Water Therapy to contact me/us as needed at phone number(s) and/or emails provided by client. It is understood that these communications may be by voice message, email, or text and will include only information about the logistics of therapy but no confidential information.
- I/We understand that suicidal threat, homicidal threat, and any abuse by an adult to a child, elderly person, or disabled person is mandated by law to be reported by Living Water Therapy and does not require my/our permission as the client and is not a breach of confidentiality. I will not hold Living Water Therapy responsible if such reports are made as required by law.

My/Our signatures below confirm that I/we have read the above information carefully, have had any questions answered, understand its contents, and agree to receive services for myself and/or any child under the age of 14 under these conditions.

Client Signatures (age 14 or older):

_____ Date _____

_____ Date _____

Witness Signature: _____ Date _____

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