

Joseph LeFevre, MA, MFT
Licensed Marriage and Family Therapist
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Informed Consent for Treatment

The Process of Therapy:

Participation in psychotherapy can result in a number of benefits to you, including improving interpersonal relationships and resolving the specific concerns that led you to seek therapy. Therapeutic services are designed to resolve or reduce problems/issues/concerns found in initial and ongoing assessments. There may be individual, family, and/or group sessions in which a variety of psychotherapeutic approaches may be utilized. Therapy may focus on feelings, thoughts, relationships, and/or behaviors. Most clients undergoing psychotherapy experience improvement, however, this cannot be guaranteed.

Working towards improvement requires effort on your part (and on your minor's part if minors are included). Psychotherapy requires your (and their) active involvement, honesty, and openness. Making life changes may be easy and swift but it can also be slow and/or frustrating. Remembering or talking about unpleasant events, behaviors, feelings, or thoughts may result in your (and your minor's) experiencing considerable discomfort during and/or between therapy sessions. Your (and their) ways of looking at, thinking about, and dealing with your (and their) life situations may be challenged. Attempting to resolve issues that originally brought you (and they) to therapy may result in unanticipated changes, in such areas as employment, relationships, schooling, housing, substance use, etc. Changes that you (or they) experience as positive may be experienced differently by those around you. I will work with you to provide the most effective treatment possible. As your open and honest contribution is essential, you will be asked for your feedback and views on your therapy and its progress periodically. Your input and/or questions are, of course, welcome at any time. Marriage and Family Therapists have professional training and you have the right to inquire fully about my credentials, education, training, and experience.

Termination:

You have the right to terminate therapy at any time. As indicated above, please keep in mind that you (or your minor) may experience discomfort prior to improvement. If at any time you believe our work together is not benefiting you (or your minor), I encourage you to discuss it in session. Also, if at any time I assess that I am not able to be effective in helping you (or your minor) to reach the therapeutic goals we set together, I am obligated to discuss it with you, and if appropriate, terminate treatment. Likewise, should we accomplish the goals, and determine that our work is indeed complete, termination would be ethically required. Upon termination, I can provide you with the names of other qualified professionals who may be of benefit to you. In any of the above instances, know that you are welcome to return to therapy at any time in the future, should you wish to do so.

Adult(s) Initial(s): 1 _____ 2 _____ 3 _____ 4 _____

Confidentiality and its Limits:

The information disclosed by you (or your minor) during the course of your therapy and contained in the written records pertaining to it, is generally confidential and may not be revealed to anyone. However, there are exceptions to confidentiality including, but not limited to, the following circumstances, as required and/or permitted by current laws and ethics binding all therapists:

- ◆ Client presents a physical danger to self, others, or property.
- ◆ There is a reasonable suspicion of child, elder, or dependent adult abuse or neglect.
- ◆ Client initiates legal action against the therapist.
- ◆ Client introduces his/her mental condition as a defense in a legal proceeding. If you place your mental status at issue in litigation during or subsequent to our work together, the defendant may have the right to obtain my records and/or testimony.
- ◆ Emergencies: If there is an emergency during our work together I may contact appropriate emergency workers, as well as the personal contacts you provide on the intake form.
- ◆ Secrets: In couple, family, and group therapy, or when different family members are seen separately, I typically will not keep secrets held among you if divulged to me. Generally, I will support you in being able to inform others yourself. However, I will also use my clinical judgment when such information affects my ability to be therapeutically effective, and/or it affects the safety, health and/or welfare of those involved.

Session Fee:

The fee of _____ dollars per 50 minute session is to be paid at the beginning of each session. Please refer to Office Policies for additional fee information.

I/we confirm by my/our signature on this form that I/we consent to my/our treatment, and that I/we have read, understand, and agree to all the conditions described above.

1.	print name	date	signature
2.	print name	date	signature
3.	print name	date	signature
4.	print name	date	signature

Please see next page also if Minors will be included in Treatment

Complete below also ONLY if Minors will be included in Treatment

I/we confirm that I/we am/are the legal guardian(s) of, and have legal custody of:

- | | |
|-------------------------------------|-------------------------------------|
| 1. _____
print minor's full name | 4. _____
print minor's full name |
| 2. _____
print minor's full name | 5. _____
print minor's full name |
| 3. _____
print minor's full name | 6. _____
print minor's full name |

and that I/we consent to treatment for this/these above named minor(s).

- | | | |
|--|------------|-----------------|
| 1. _____
(print) Parent/Guardian Name | _____ Date | _____ Signature |
| 2. _____
(print) Parent/Guardian Name | _____ Date | _____ Signature |
| 3. _____
(print) Parent/Guardian Name | _____ Date | _____ Signature |
| 4. _____
(print) Parent/Guardian Name | _____ Date | _____ Signature |