FAMILY STRATEGIES
COUNSELING CENTER

CLIENT INFORMATION and INFORMED CONSENT

Please read ALL information carefully and thoroughly and initial where indicated. *Revised 8.26.21*

NOTE: If you are seeing a therapist at Family Strategies for couple's therapy, each person must fill out a separate set of forms for your first couple's session.

WELCOME

It takes courage to reach out for support and we look forward to supporting your healing journey. These forms contain information about Family Strategies' professional counseling services and business policies. It is important that you review the following information before beginning your first session. Please feel free to ask any questions you may have about these policies; we are happy to discuss them with you. There are multiple places where your signature will be required on the following forms.

THERAPY SERVICES - RISKS and BENEFITS

_____ (*initial*) The role of a licensed counselor is to assist you with challenges that may impact you emotionally. Counseling often involves discussing difficult aspects of your life. During our work together you may experience uncomfortable feelings such as sadness, guilt, shame, anger, or frustration. As a result of what comes out of your therapeutic work and the decisions you make, important relationships may be impacted or may end. Your journey in therapy may also lead to healthier relationships. If you ever have concerns about your therapy process, I encourage you to discuss this with your therapist during your sessions so that we can collaborate together as you move forward.

TERMINATION of THERAPY

_____ (*initial*) You may terminate therapy at any point. When our work comes to an end, we ask that you schedule at least one final session in order to review the work you have done. Occasionally clients return to therapy to process new challenges. If you decide to return in the future, please know that we have an open-door policy and we welcome the possibility of working together again. However, it will be at our clinical discretion and also dependent on your therapist's availability. There can be a wait of up to 2-4 weeks. If your therapist is unable to see you immediately, we will be happy to add you to the waiting list, or provide you with a referral to another competent therapist(s).

Your therapy records are closely protected and maintained for six (6) years after the last date of treatment. If you would like to obtain a copy of your treatment records, you can do so by sending a written request directly to your therapist at our office.

LENGTH of THERAPY

_____ (*initial*) Therapy is a process that is unique to each client and the challenges they are experiencing. Some issues can be worked on very effectively in a short period of time, and other challenges may take much longer. It can be difficult to predict exactly how long therapy will last so this is best discussed in your first session. You and your therapist will put together a treatment plan and goals that you will be working toward. If you have questions regarding the length of treatment, please feel free to discuss this with your therapist at the start and/or at any point during therapy.

DUAL THERAPY

_____ (*initial*) It is unhelpful for two different therapists to provide counseling for the same client at the same time. Unless there is a compelling clinical reason, a crisis, or a specialized therapy treatment plan that we will be working on, we do not work with clients who are under the care of another therapist outside of Family Strategies. If you are working with another therapist outside our office, please disclose this so that you can discuss next steps with your Family Strategies therapist. If your therapist has referred you to Family Strategies for specialized treatment (i.e. sex addction, sex therapy, etc.), we will need to have a release on file from you in order to coordinate care with your primary therapist and collaborate on a clinical plan that best supports your process.

CONJOINT SESSIONS

_____ (*initial*) On occasion, and only if it benefits the client's therapy goals, your therapist may invite you to ask a family member or significant other to join you for a therapy session. It is important to note that this is done only on occasion and at your therapist's clinical discretion when it best serves the client. If the person joining the session is your significant other, this does not constitute as couple's therapy, rather it is as a support to your work, and/or a check-in session. Additionally, the third party (friend or significant other) is not joining the session for his or her own therapy, nor will your therapist work with them as a therapist.

NO SECRETS POLICY

_____ (*initial*) Please note that with couples therapy the couple is the client (e.g. the treatment unit), not the individuals. As such we practice a "no secrets" policy when conducting marital/couples' therapy. This means that confidentiality does not apply between the couple when one member of the treatment unit requests an individual session or contacts the couple's therapist outside of the therapy session to share a secret. Secrets do not include personal thoughts, feelings, desires, etc. of one of the parties, rather information that would be painful, harmful, or betraying to the other partner (i.e. affairs, financial betrayal, etc.). On occasion an individual session may be scheduled to assist in the overall therapy process to the treatment unit (e.g. the couple) and will be scheduled only when mutually agreed upon. Please understand that the majority of information shared in the individual sessions will not be held in confidence or secret in the couple's sessions. Your therapist will encourage the person holding the secret to share the secret in the following session and will support the client in doing so. Your therapist also reserves the right to share or disclose information revealed by one partner in an individual session to the other partner or family members as deemed appropriate or necessary to support the treatment unit's overall treatment progress and goals.

SOBRIETY POLICY

_____ (*initial*) Family Strategies asks that all clients, couples, families, and group members arrive at therapy sober and not under the influence of drugs and/or alcohol. If any member of our staff notices that you are intoxicated or substance impaired, the therapy session will be immediately terminated. Once you are safely home, you may reschedule the therapy session. You will be charged your full fee for the session if you arrive intoxicated or impaired.

PHYSICAL CONTACT

_____ (*initial*) Sexual contact is never acceptable in the therapeutic relationship. In some cultures, a supportive hug or other physical contact can be an expression of affection, or a greeting, or a goodbye. However, supportive physical contact can also be misconstrued, triggering, or may interfere with the therapeutic relationship. As a general policy our therapists do not offer supportive physical contact of any kind within the therapeutic relationship. Please understand, this is not an expression of judgment, dislike or dismissal, rather it is in the best interest of your clinical care based on a professional and therapeutic boundary. You always have the right to refuse physical contact at any time or for any reason.

CONFIDENTIALITY

_____ (*initial*) Therapy is best experienced in an atmosphere of trust. Thus, all therapy services are strictly confidential and may not be revealed to anyone without your written permission. **There are exceptions to confidentiality where disclosure is required by law (see below).** Your confidentiality is very important to us. Should you request that your therapist speak with another professional or person (i.e. doctors, former therapists, teachers, family, friends or anyone else outside the therapy room), you must first provide your signed written consent in order to do so and only after your therapist determines if this is in the best interest of supporting your therapeutic process and progress. There are times when consulting with adjunct clinicians can be very helpful in providing you with the best possible care. As a member of the therapeutic team at Family Strategies, your therapist has a unique opportunity to utilize the vast experience and expertise of other clinicians.

In an effort to provide me with the best possible care, I hereby authorize my therapist to exchange confidential information regarding my treatment to other professional clinical staff at Family Strategies, LLC. Professional staff includes, but are not limited to, the Executive Directors, Clinical Supervisors, and other therapists who have expertise regarding specific clinical issues and treatment planning. I give this authorization of my own free will and have discussed any questions or concerns with my therapist. By signing this consent to exchange confidential information, I acknowledge that I have both read, understood and that I agree to all the terms of this release. I understand that my records are protected under Federal and State Confidentiality Regulations.

Client's Signature *Date*

LEGAL EXCEPTIONS to CONFIDENTIALITY

_____ (*initial*) Your information is always confidential with the exception of information relating to child abuse, suspected child abuse, elder abuse, dependent adult abuse, or intent to harm self or others, or unless mandated by a court of law. Legally, therapists are mandated reporters of abuse or intent to harm another. If you are suicidal or homicidal your therapist at Family Strategies will take all reasonable steps to prevent harm to you or another.

A minor is defined as any person who is legally under the age of 18. Wether your therapist works with minors or not, they are mandated reporters of any sexual acts involving minors. This means that if any therapist or staff at Family Strategies learns of any incident involving minors and illegal sexual activity, or other types of abuse or neglect, they are legally required to report this to the proper authorities.

I understand the above stated limits of confidentiality and mandated reporting responsibilities of my therapist and Family Strategies.

Client's Signature *Date*

COURT REPORTS or LETTERS, COURT HEARINGS

_____ (*initial*) The therapists at Family Strategies do not write legal letters or court reports on behalf of clients involving divorce, custody or other legal matters or lawsuits. We do not write letters pertaining to legal matters to any outside person (i.e. doctor, school, attorney, etc.) or agency regarding your treatment. If a special circumstance arrives where a letter is required by court order, it will require your written consent and will be billed to you at $25.00 per page and in addition to your therapist's hourly fee.

As a general policy the therapists at Family Strategies are not forensic specialists and prefer to not testify or participate in court proceedings on behalf of a client as that has the potential of changing the overall purpose and scope of our services. If you become involved in legal proceedings that require mandated participation by your therapist, you will be expected to pay for all of your therapist's professional time including preparation and transportation time and costs, even if called to testify by another party regarding your case. Because of the time involved and the interruption to your therapist's clinical work and compensation, you will be charged $350.00 per hour for preparation, travel, and attendance at any legal proceeding on your behalf. A detailed accounting of time is available to you upon request.

Court fees can be very expensive. Please sign and date below to indicate that you understand your financial responsibility in covering these expenses should we be mandated to go to court for a legal issue you are involved in. Your therapist is not a court advocate or friend. A therapist must legally speak truthfully under oath.

Client's Signature *Date*

THERAPY SESSIONS and FEES

_____ (*initial*) The fee for a standard therapy session at Family Strategies varies by therapist. The standard therapy session is 45 - 55 minutes in length. Therapy can be conducted in person in the office, via phone, or videoconference. It is understandable that occasionally you may be late. If you are late to your session, please understand that the session will not extend past your allotted time, nor will the time be made up at future sessions. Therapy sessions are paid via credit card, check, or cash. Please fill out the credit card form included in this packet and bring with you to your first session. If paying with cash, please bring the exact cash amount for your session fee as Family Strategies does not normally keep cash on premises.

Fees are reviewed annually and may increase periodically. The increase will be discussed with the client, and a 30-day notice will be posted prior to the increase. Your therapist is happy to answer any questions you may have about this fee agreement. Please understand that you have the right to terminate therapy at any point. If you have any questions regarding the fee policy, please do not sign until discussing with your therapist.

APPOINTMENTS and CANCELLATIONS

_____ (*initial*) Appointment cancellations made less than 24 hours before the scheduled appointment will be charged the full agreed upon fee for the session. If you do not show up for a scheduled appointment (that you have not called to cancel within 24 hours) you will be charged the full fee for the session. You are responsible for keeping track of and attending your sessions. *If you are sick or experiencing any symptoms of illness, please call the office ahead of your appointment and ask to conduct your session via the phone or videoconference. If your therapist is ill, the same consideration will be extended to you.*

THERAPIST AVAILABILITY BETWEEN SESSIONS

_____ (*initial*) Your therapist may be available to answer a short email regarding your therapy appointment times or therapy homework no more than twice per month without charging a fee. We will not process therapy issues via email unless you have been specifically instructed to do so as part of your treatment. If therapeutic services are required during non-business hours you will be charged 25% of your therapist's rate for every 15 minutes.

E-THERAPY - i.e. TELEMEDICINE, TELETHERAPY, CYBERTHERAPY, etc. (when applicable)

_____ (*initial*) E-therapy is the use of electronic media and information technologies to provide mental health services in different locations. There are limitations and risks associated with e-therapy, including inherent confidentiality risks of electronic communication and potential for technology failure. If there is an emergency and the therapist is unavailable, you should call 9-1-1. If video is not available, the therapist will ask for identification. You will also be asked about your physical location during the telemedicine encounter, as well as verification that the setting provides for your confidentiality.

Family Strategies does not allow either the counselor or client to record any portion of video or telephonic therapy sessions unless prior consent has been obtained in writing for the purpose of training or supervision.

By signing below, you recognize that if there is an emergency and your therapist is unavailable, you should call 9-1-1. You also acknowledge that if video is not available, your therapist will ask for identification. You will be asked to provide your therapist with your physical location during the encounter, and verification that your setting provides for your confidentiality.

Client's Signature *Date*

THERAPEUTIC APPROACH and STYLE

_____ (*initial*) Our goal at Family Strategies is to help people navigate through difficulties in their life and relationships while providing a safe place to heal, explore, develop insight, practice healthy coping tools, and integrate and take responsibility for their changes. Our therapeutic approach is collaborative, honest, challenging, and direct with solid boundaries and empathy. We use a variety of client-centered modalities with clients.Your therapist may reflect, assist, encourage, and point out incongruent patterns around actions and words. Your therapist will formulate the therapeutic plan collaboratively with you based on your needs, presenting problems, and the goals you wish to achieve. At Family Strategies, we believe that each client has the potential for healing and change, is responsible for their choices and changes, and for meeting their therapy goals – *we do not make guarantees for healing.*

INFORMED CONSENT

_____ (*initial*) Therapy is an interactive process between client and therapist, and the results of therapy depend on your cooperation. Therapy is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times, very fulfilling. You will be expected to contribute to all decisions regarding therapeutic intervention devised for you, including out of session assignments. You have the right to refuse or alter any service and intervention. While your therapist will use their best effort to assist you, there can be no assurances of results, and no promises can be made regarding the outcome of any service provided. You should question the rationale of any service, intervention, and discussion if these seem unclear to you. Your signature below indicates that you understand that there are risks for noncompliance with treatment recommendations, and that you will discuss these risks with your therapist.

GROUP THERAPY

_____ (*initial*) Due to the nature of group therapy, neither Family Strategies nor its therapists may release group records without compromising the confidentiality of other participants, which is prohibited by Arizona law. All group records are stored "together" on a single form, which makes individual notes for the group unavailable for copy and release. If you, as a client, require group records for any legal reason, you (or your health care decision maker) must make such a request in writing, and Family Strategies and its therapists are restricted to supplying only dates of service and general topics reviewed during classes and group sessions.

CLINICAL SUPERVISION_

_____ (*initial*) Your therapist _____is under clinical supervision as an associate licensed counselor with the Arizona Board of Behavioral Health, or is a University intern studying for a Masters Degree, and provides therapy under the clinical supervision of Dr. Floyd Godfrey, PhD, Dr. Kim Buck, PhD, John Hinson, LPC, Abbie Ashton, LMFT, Angie Hatch, LPC, and/or John McLean, LPC who are qualified to provide supervision within the state of Arizona according to the laws and regulations set forth by the Arizona Board of Behavioral Health. You can contact any of the above mentioned supervisors by calling 480-668-8301.

FINANCIAL RESPONSIBILITY

_____ (*initial*) You (or responsible party) are considered responsible for payment of professional services. When you request to bill a third party, such as an insurance company, and that third party fails to make payment within 30 days from the date of billing, the client or responsible party is expected to pay within 10 days of receipt of the statement. Bills not paid within 30 days from the date of billing will be subject to an interest charge of 10% of the outstanding bill.

ROI CONSENT

_____ (*initial*) In efforts to provide me with the best possible care, I hereby authorize my therapist to share confidential information regarding my treatment with other professional staff at Family Strategies. Permitted disclosures include, but are not limited to, discussion and sharing and/or providing access to my records as appropriate, which includes, but is not limited to, treatment plans, intake assessments and progress notes. "Professional staff" includes, but are not limited to, the Executive Team, Clinical Supervisors, therapists and interns who have expertise regarding specific clinical issues and treatment planning. I give this authorization of my own free will and have discussed any questions or concerns with my therapist. By signing this consent to exchange confidential information, I acknowledge that I have both read, understood and that I agree to all the terms of this release. I understand that my records are protected under Federal and State Confidentiality Regulations. I understand that I may revoke my consent at any time by written notice, and that my participation in Family Strategies' treatment program(s) is conditional on the above consent.

INFORMED CONSENT

I voluntarily agree to receive mental health assessment, care, treatment or services and authorize the undersigned therapist to provide such. I understand and agree that I will participate in the planning of these services and that I may stop such care at any time. By signing this consent form, I acknowledge that I have both read, understood and that I agree to all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification on anything unclear to me. I also acknowledge that I have received a copy of **"Client Rights"** and **"Complaint/Grievance Procedures"** as well as the **"Notice of Privacy Policies – HIPAA"** documents.

_____

Client Signature *Date*

_____

Printed Name of Client

_____

Therapist Signature *Date*

CONSENT FOR TREATMENT OF MINORS UNDER THE AGE OF 18

I, _____ (*print name of legal guardian*) am the parent or legal guardian with legal custody of_____ *(print name of client)***,** and give permission to FS to provide counseling services for my child.

NOTE: If parents are divorced, court custody documents must be provided prior to the first session. If parents share joint custody, both must sign the "Client Consent" form.

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Signature of parent/legal guardian *Date*