Postpartum and Relationship Counseling, LLC

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Informed Consent for Assessment and Treatment

Welcome to Postpartum and Relationship Counseling, LLC. Please take a moment to review the information included in this packet. A counseling situation offers a unique relationship between the client and therapist. This document has been created to communicate what can be expected from our therapeutic work together.

As a Licensed Associate Marriage and Family Therapist, I, Teresa (Teri) Ehlers, LAMFT #10551 am recognized by the Arizona Board of Behavioral Examiners (AZBBHE "Board") as a Licensed Associate Marriage and Family Therapist. I am working towards independent licensure and am operating my own entity as, Postpartum and Relationship Counseling, LLC. I have immediate responsibility for the behavioral health services provided to you and having obtained prior approval from the Board to provide such services, I am under direct supervision provided by Dr. Carolyn Pela, LMFT #10010, approved clinical supervisor. My supervisor, Dr. Pela will have access to all clinical records and by signing below you are authorizing the release of these records to the supervisor. As an LAMFT in Independent practice I am required to meet with my supervisor 1 (one) hour for every 20 client hours.

Please initial on the lines provided to indicate that you have read and understand these policies and that you freely and willingly agree to enter into and participate in treatment.

I understand that in accordance with the supervision requirements set forth by the AZBBHE, Teri Ehlers, LAMFT will discuss client information with her supervisor. The purpose of disclosure during supervision is to ensure that all clinical services provided are effective and ethical. Client information disclosed during supervision includes identifying information; presenting problem, treatment goals and therapeutic models/techniques; and any subject matter discussed in session. Supervisor will have access to all clinical records and I authorize the release of these records to the supervisor.

PATIENT RIGHTS: Treatment begins with an intake assessment session in order for me to better understand your reason for coming for therapy at this time and includes your background and any other factors that may be relevant. From the information gathered during this intake session we will together, develop a treatment plan. You have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdraw. The therapist reserves the right to refer a client to another therapist or appropriate resource at any time if it is determined that client/therapist match is not best for therapist's skills or experience.

PURPOSE, LIMITATIONS AND RISKS OF TREATMENT: Counseling, like most endeavors in the helping professions, is not an exact science. While the ultimate purpose of counseling is to reduce your distress and help foster desired change, through a process of assessment, exploration and interventions, there are no guarantees that the treatment provided will yield positive or intended results. Moreover, the process of counseling usually involves working through tough personal issues that can result in some emotional or psychological pain for the client. Attempting to resolve issues that brought you to therapy may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships or virtually any other aspect of your life. Sometimes a decision that is positive for one family member or significant other is viewed quite negatively by another family member or significant other. In the case of marriage counseling, interpersonal conflict can increase as we discuss and seek to resolve family relational issues.

Minors are typically seen in some form of family therapy to include at least one adult also participating in treatment. ***In cases of divorce, consent must be obtained from all parents with custody***.

POSTPARTUM COUNSELING: Research shows that it is beneficial for individuals struggling with Postpartum or Perinatal mood disorders to include couple or family therapy as a component of care. Therefore, I encourage all clients to schedule conjoint sessions to include significant other or appropriate family members identified by the client.

EXPLANATION OF COUNSELING FEES: I understand that payment for counseling is expected at time of service. Counseling fees: $110.00 per each 50 minute individual counseling session or $125.00 for couple or family 90 minute session. If necessary, these fees can be modified ahead of time based upon client's ability to pay.

APPOINTMENTS: I understand that regularly attending scheduled appointments is one of the ways for successfully meeting my treatment goals for therapy. Appointments cancelled with less than 24-hour notice or appointment No Shows will be charged at the regular rate for the missed session.

PRIVACY, CONFIDENTIALITY, AND RECORDS: Ordinarily, all communications and records created in counseling are held in the strictest confidence. However, there are exceptions to confidentiality defined in the state and federal statutes. These exceptions include situations in which there is a real or potential life or death emergency, when the court issues a subpoena, or when child/adult or disabled individual abuse or neglect is suspected. If, as your therapist, I have reason to believe that a client is threatening serious bodily harm to *him/herself or an identified other I am required by law to take protective actions*. These actions may include notifying the intended victim, contacting the police, and/or seeking hospitalization of the client.

If a client threatens serious bodily harm to self, I am required as your LAMFT therapist to take actions including, but not limited to, establishing a *Suicide Prevention Contract,* contacting the client's emergency contact/family member, and/or seeking hospitalization. Only the minimum amount of information will be shared in order to keep the client safe.

In the event of court mandated appearance of Teri Ehlers, LAMFT, Postpartum and Relationship Counseling, LLC, in court I understand that a fee of $500.00 an hour will be accrued and is my financial responsibility.

RETENTION OF CLIENT RECORDS: Client records are kept by the therapist for six years after last date of services provided for adults, and for child clients three years past client's 18th birthday or six years after last session (whichever date occurs later). These records are kept according to HPPA requirements.

CLIENT RIGHTS TO ACCESS RECORDS: All client records and all information concerning the client are kept confidential. In order to access your records, there must be a signed released by all identified clients. All requests must be made in writing. A summary of client notes will be prepared and a fee of $110.00 an hour will be assessed.

DELIVERY OF MENTAL HEALTH CARE THROUGH TELEMEDICINE: REQUIREMENTS AND EXCEPTIONS "Telemedicine" means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video, or data communication that occurs in the physical presence of the client/patient, including audio or video communication sent to a health care provider for diagnostic or treatment consultation.

Before a healthcare provider delivers healthcare through telemedicine, the treating healthcare provider must obtain verbal or written informed consent from the client or client's healthcare decision maker. If verbal consent is given the provider must document in consent form.

AVAILABILITY OF SERVICES: My practice does NOT have the capability to respond immediately to counseling emergencies. True emergencies should be directed to (911) or **Empact Crisis (480) 784-1500.** In the event of the emergency let me know by phone or text at (480) 234-3461 and I will call you back, usually within 24 business hours.

CLIENT/THERAPIST RELATIONSHIP: The client/therapist relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and the therapist to spend time together socially. The purpose of these boundaries is to ensure that you and I are clear in our roles for your treatment and that your confidentiality is maintained.

VIDEO/AUDIO RECORDING - ***I may request to video or audio record a portion of your session to comply with the AZBBHE requirement for live supervision*.** If you are *not* comfortable with this *feel free to decline*. If you are comfortable with it, any recordings are destroyed *immediately* after their use in supervision.

Any questions or concerns pertaining to Teri Ehlers, LAMFT should be directed to my supervisor:

Dr. Carolyn Pela, LMFT
Carolyn.pela@arizonachristian.edu
602-489-5300 x2100

This consent and authorization will be in effect for **one year** from the date signed or until the therapeutic relationship has ended unless parent or guardian chooses to revoke at any time in writing to the email address above. This signature acknowledges that the therapeutic relationship has been entered into freely and voluntarily.

CONSENT FOR TREATMENT: I, (Client/parent/guardian)

(I), _____
Authorize and request that Teri Ehlers, LAMFT 10551 provide mental health counseling/therapy services including, but not limited to diagnostic assessment and behavioral health treatment advisable for the course of my care or the care of my minor child.

_____ _____
Signature of Client (or person acting for client) **Date**

_____
Relationship to Client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of Therapist **Date**

_____ _____
Signature of Supervisor **Date**

Client Name _____ C.I.D. # _____