

Informed Consent and Therapy Contract

We feel it is important that, as a client, you are fully informed about the therapy services you will be receiving. Your signature below indicates that you have received, read, and understand the practice policies of this therapy in helping you make an informed decision about entering therapy.

- I agree to cooperate fully and to the best of my ability with the counseling process and in the development of treatment goals and plans.
- I understand the therapist, Nicole Larson, MSW, LCSW, will use her best efforts, skills, resources, training, and experience in good faith. She will make use of the specific techniques in which she has been trained with your best interest in mind. Nicole will continually monitor the progress of therapy.
- While Nicole will check messages and voicemails regularly, she does not provide 24 hour service or crisis care. In the event of an emergency, please go to the nearest emergency room or call the appropriate hotline in your county for immediate assistance: **Washington County Hotline 503-291-9111; Clackamas County Crisis Hotline 503-655-8401; Portland Crisis Hotline 503-988-4888.**
- Clients may use email or text messaging to make or reschedule appointments, at their request. These methods, while convenient, carry an inherent risk of being accessed by unauthorized people, which can compromise your privacy. These methods are never acceptable methods for communicating private, personal information.

If you request to use these methods for scheduling convenience, please initial below that you acknowledge the risk of sending personal information by email or text message and consent to communicating with your therapist using these methods:

Email _____ Text message _____

- I understand Nicole is a licensed clinical social worker and therefore is bound by the Code of Ethics set forth by the National Association of Social Workers and that I can request a copy of those ethics at any time.
- I understand that, except under specific circumstances mandated by law, communication with my therapist will remain confidential as will any records regarding the therapy process unless I sign an "Authorization to Exchange Confidential Information" Form thereby authorizing access to the information by a specific person/agency before any file information will be released. If more than one family member participates in a session, each and every participating family member must consent prior to the release of the file information. The client's family members are not entitled access to client information just because they are family.

- I understand that, due to legal or ethical obligation, specific circumstances may require my therapist to break confidentiality and report information obtained as a result of the therapy process. Those circumstances exist when: a) the therapist believes a client may be a danger to him or herself or to others; b) the therapist believes that a child, elderly or disabled person may be subject to abuse or neglect; and, c) when a court order exists that information regarding the therapy process be provided.
- I understand that I am entering into a professional relationship with my therapist which prevents us from entering into any other relationship such as a friendship or business relationship. Therapists will not use social media with clients. As your therapist it is my responsibility to protect your privacy if we meet in a public place, so I will not initiate contact or acknowledge you in a public setting. Of course you can do so if you choose and I will follow your lead.
- I understand that there are risks and benefits associated with therapy. Therapy may stir up unpleasant emotions and memories that may cause you to feel the problem is worse before it gets better. Regular sessions most often correspond to favorable results.
- If you have concerns about how your counseling is progressing, we encourage you to bring this up with your therapist. You may request a change in how we do therapy, a referral to another therapist, or to discontinue therapy. You may leave therapy at any time and agree to discuss the termination of therapy at a regular therapy session.
- I agree to pay \$_____ for therapy at the beginning of each session. I know that I must call to cancel an appointment at least 24 hours in advance. If I do not cancel or do not show up, I will be charged the full session price for that appointment. Returned checks are subject to a \$25 service fee. We accept cash and checks.
 - o The cost of my sessions will be covered partially or fully by another person or agency.
 - Yes | No
 - If yes, name of agency or person _____
 - Fee per session that will be paid by agency or person \$ _____
- Credit card processing involves the use of a third party agency. I acknowledge this use of my confidential information and consent to the release of my personal information including my name, session date, and fees to the agency my therapist uses for credit card processing.
- Emergency Contact: _____
My therapist has permission to contact the above in case of an emergency or if we reasonably suspect a third party or I is in danger.

My signature below indicates that I give my full and informed consent to receive individual, couples, or family therapy services from this therapist.

Client Signature _____ Date _____

Therapist Signature _____ Date _____