

## INFORMED CONSENT

**Welcome to my office. As a licensed marriage and family therapist, I am governed by certain laws and regulations and by the code of ethics for my profession. The ethics code requires that I make you aware of certain office policies which may affect you. Please take a moment to read the following information.**

### I. Your Rights as a Client

You have the right to ask questions about any procedures used during therapy.

You have the right to decide at anytime not to receive therapy from Mary Bermani. If you wish, she will provide you with the names of other qualified professionals whose services you might prefer.

You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued.

### II. Confidentiality

Within certain limits, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your permission. At times, therapy will involve the participation of more than one family member and/or significant person(s). While Mary Bermani will attempt to follow your wishes, she does not guarantee confidentiality among participants in the family or couples therapy.

There are certain situations in which Mary Bermani is required by law to reveal information obtained during therapy to other persons or agencies without your permission. These situations include:

- a. If you threaten bodily harm or death to another person, Mary Bermani is required by law to inform the intended victim and appropriate law enforcement agencies.
- b. If you threaten bodily harm or death to yourself, Mary Bermani will inform the appropriate law enforcement agencies and others (such as a spouse, friend, or an inpatient psychiatric institution) who could aid in prohibiting you from carrying out your threats.
- c. If you reveal information related to the abuse or neglect of a child, dependent adult or elderly person, Mary Bermani is required by law to report this to the appropriate authorities.

## **“No Secrets” Policy for Family Therapy and Couple Therapy**

This written policy is intended to inform you, the participants in family therapy or couple therapy, that when I agree to work with a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (the treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit — that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the \_\_\_\_\_ (couple/family or other unit) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Mary Bermani and that we enter couple/family therapy in agreement with this policy.

**Each family member must initial:**

Initials \_\_\_\_\_ Initials \_\_\_\_\_ Initials \_\_\_\_\_ Initials \_\_\_\_\_

### III. Minors

**If you are the guardian of a minor or are a minor, please read the following:**

By signing below, I give my consent for Mary Bermani to conduct therapy sessions with the minor listed below. I have also been informed of the limitations to confidentiality in terms of the treat to me about certain topics such as substance use and sexual activity. I accept Mary L Bermani's judgment in regards to releasing information related to the treatment of this minor. In addition, I understand that at anytime if Mary Bermani believes this minor is in danger of hurting him or her-self, I will be notified immediately.

### IV. Emotionally Focused Therapy

(If you are NOT coming for couple's therapy, you may skip this section)

EFT is a short term (8-20 sessions, though in some cases longer) structured approach to couples therapy formulated by Susan Johnson and Les Greenberg in the early 80's. The strategies and techniques of EFT are also used with families. A substantial body of research outlining the effectiveness of EFT now exists. This research demonstrates that couples significantly improve over the course of treatment and continue to get better at two year follow up. Please refer to the EFT website for further information about the treatment model and present outcome research. [www.eft.ca](http://www.eft.ca)

The Goals of EFT are:

1. To expand and re-organize key emotional responses
2. To create a shift in partner's interactional patterns with one another
3. To foster the creation of a SECURE bond between partners/families

### V. Consent for EFT Consultation Live and Group:

In order to provide the best possible therapy treatment for you and your family, it is common for Mary Bermani to participate in consultation and training groups with seasoned mental health professionals on a regular basis. At some point in treatment, you may be asked to participate in a therapy session which will be observed by a live consultation and/or training group.

If you give consent, during these consultation and/or training groups, Mary Bermani will present your case(s) to the group via audio or video tape. Typically, a ten minute segment of your confidential session will be shared with the group, along with a summarization of the presenting problem(s) and relationship history. Absolutely, **no identifying information** is presented to the consultation and/or training group members. After the case has been presented, the professionals in the group will collaborate with Mary Bermani on how to best work with the presenting relationship dynamics. Mary Bermani will take record of the feedback and recommendations and will then review this information with you at your next session. Mary Bermani will notify you ahead of time if this is going to happen so that you have the opportunity to revoke consent after the session(s) have been recorded.

The mental health professionals in the consultation and/or training group must follow the same confidentiality guidelines as Mary Bermani. If by chance someone in the consultation or training group was to know you or a member of your family, they will be asked immediately to leave the group and will not be permitted to participate in the portion of the meeting involving your case. Your case information and the copy of your recorded session will remain with Mary Bermani and will not be reproduced or shared at any point. Once the review has taken place, your session file and/or dvd copy of your session will be deleted permanently.

By initialing below, I give my consent to allow a small designated segment of my confidential therapy session(s) with Mary Bermani to be:

\_\_\_\_\_ a) Observed by an EFT live consultation and/or training group with minimal background  
\_\_\_\_\_ relationship and clinical history revealed.

\_\_\_\_\_ b) Recorded via video or audio tape and used for Mary Bermani's review only.  
\_\_\_\_\_

## VI. Contact Information

Mary Bermani can be reached at (562) 760-7645, Monday through Thursday 8am to 8pm. If you have a counseling emergency after hours, you may call, however, response times will be longer, or you may dial 911.

**Email communication is for non-emergencies only.** It may be used for appointment changes, referrals and non-clinical questions. I check my emails as often as possible, but if you are canceling an appointment with less than 24 hours notice, please call my cell phone number.

mary@marybermani.com

## VII Signatures

The undersigned, by providing his/her signature in the space below agrees to accept the therapy services provided by Mary Bermani, LMFT in accordance with and pursuant to the terms and conditions set forth herein.

1) Name (Please Print) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

2) Name (Please print) \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_\_

3) Parent or Legal Guardian (Please print) \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_\_

## FEE ACKNOWLEDGMENT AND AGREEMENT

The undersigned, by providing his/her signature in the space below agrees to accept the therapy services provided by Mary Bermani in accordance with and pursuant to the terms and conditions set forth herein.

The fee for your initial evaluation has been set at: \_\_\_\_\_. Subsequent treatment provided by the above mentioned, will be billed at a rate of: \_\_\_\_\_ per 80 minute session. Treatment provided by the above mentioned, will be billed at a rate of: \_\_\_\_\_ per 50 minute session. If your session goes longer or if you are participating in intensive therapy, your fee for this service will be negotiated with your therapist and the amount agreed will be charged to your card at the end of each therapy session.

A therapy hour is fifty minutes to an hour. You are encouraged to schedule appointments as you feel will be of need to you. If you are unable to attend your scheduled appointment, you must call 24 hours in advance or you will be charged a full session fee. Additionally, if your personal check is returned for insufficient funds you will be charged a \$25 fee.

Payments are required at the time of your appointment, unless other arrangements have been made in advance. If at any point in the course of treatment you are unable to pay for your fee, please communicate this to your therapist and your fee will be negotiated.

All fees are expected to be paid at the end of your therapy session.

All outstanding balances remaining unpaid more than 30 days will be charged directly to your credit card. If the credit card does not authorize payment, you are subject to interest accrued at a rate equal to 10% per annum of such outstanding balance.

The undersigned hereby authorizes Mary Bermani to charge my credit card (provided below) for the amount of any balance remaining at the end of each therapy session or after a balance has been unpaid for 30 days.

I am also authorizing Mary Bermani to charge my card when I do not show up for my scheduled appointment or if I cancel in less than 24 hours notice. The charge for a "no show or late cancellation" is the same as a full session fee, agreed upon in this document.

**Preferred method of payment (please circle one):**    **credit card**    **check**    **cash**

### Credit Card Information

The undersigned hereby authorizes Mary Bermani to charge my credit card (provided below) for the amount of any balance remaining at the end of each billing period. If payment by check is the preferred method agreed upon, the following card will only be charged if there is an outstanding balance more than 30 days after issuance of an invoice.

**A current credit card number must be on file at all times, regardless of your preferred method of payment.** Your card will not be charged if you choose to pay by check at the time your payment is due. If credit is your preferred method of payment, your card will be charged at the end of each session for services rendered . All paid invoices are emailed to the card holder at time of charge.

The credit card to remain on file is:

1. Please Circle:            MasterCard            Visa
  
2. Card Number: \_\_\_\_\_
  
3. Expiration Date: \_\_\_\_\_
  
4. Security Code: \_\_\_\_\_
  
5. Name as appears on the card: \_\_\_\_\_
  
6. Billing Address with zip code: \_\_\_\_\_  
\_\_\_\_\_
  
7. Signature of card holder: \_\_\_\_\_

## Payment by Check

All payment by check must be submitted by the 10<sup>th</sup> of the month following receipt of an invoice. All invoices are for services rendered the previous month and payment will be considered late if not received by the due date posted. All invoices are emailed at time of billing cycle and a PAID invoice can be submitted upon request.

**The Undersigned understands and agrees to be bound to such agreements as outlined in this document. Please provide your signature below. If there is more than one adult participating in treatment, both must sign below.**

SIGNATURE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

DATE: