5745 E Central Avenue, Wichita, KS, 67208
316-260-6889

Informed Consent And Therapy Contract

As a client, it is important that you are fully informed about the services you will receive. Your signature below indicates that you have been informed of the policies of this therapist and you are making an informed decision about entering therapy.

1. I understand that my therapist is an independent provider licensed in the State of Kansas to diagnose and treat mental disorders. I understand my therapist is a Licensed Clinical Marriage and Family Therapist (LCMFT) and not a medical doctor. As such, she is not licensed to prescribe drugs.

2. I understand that my therapist is bound by the Code of Ethics set forth by the American Association for Marriage and Family Therapy (AAMFT) and that I can request a copy of those ethics at any time.

3. I understand that, as a client, I have certain rights and those rights have been reviewed with me by my therapist. (See CLIENT BILL OF RIGHTS)

4. I understand that, except under circumstances mandated by law, communications with my therapist will remain confidential as will any records regarding the therapy process unless I sign an Authorization & Request for Release of Confidential Information and Privileged Communication Form authorizing access to the information before any file information will be released in accordance with K.S.A. 65-6410. 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. Where a minor is receiving services, the appointment of a guardian ad litem may be necessary prior to the release of the minor client's information. The client's family members are not entitled access to client information just because they are family.

5. I understand that, in accordance with state regulation and/or professional ethics, specific circumstances require my therapist to break confidentiality and report information obtained as a result of the therapy process. Those circumstances exist when: a) my therapist believes a client may be a danger to him or herself or to others; b) my 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.

6. I understand that, if the therapist or client records are subpoenaed to court on my behalf, I may be responsible for charges associated with time spent by my therapist to prepare and furnish these records and/or appear in court.

7. I understand that, under Kansas Law, my therapist is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to symptoms of a mental disorder. In order to complete such a consultation, my therapist will request that I complete a Release of Information form. I also understand that I may waive this consultation, in writing, and that my therapist will discuss this process with me at any time if I so request. (See PHYSICIAN CONSULT WAIVER)

8. I understand that there can be risks and benefits associated with therapy. Because therapy often involves discussing unpleasant aspects of life, I may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. Therapy has also been shown to have benefits. I understand therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. While the process is effective for many people, I understand there are no guarantees of success.

9. I understand the financial policies of the therapy site and agree to pay the assigned fee. I understand that payments or co-payments are due at the beginning of each session. I understand I am responsible for cooperating with my insurance company to support prompt payment. I understand that if my insurance company does not pay for treatment that I will be responsible for payment in full. I understand that the therapist has the right to seek legal recourse to recoup any unpaid balance. In pursing these measures, the therapist will only disclose biographical information and the amount owed in order to ensure confidentiality.

10. I agree that if I need to cancel or reschedule an appointment that I will let my therapist know 24 hours in advance of the appointment. If I do not meet this requirement, I will be charged $25 for the first occurrence and $100 for any additional occurrences.

11. I acknowledge that I have received and been given opportunity to review the ICT THERAPYWORKS PRIVACY NOTICE. (See HIPAA PRIVACY POLICY)

Client signature _____ Date _____

Printed name _____ DOB _____

Therapist signature _____ Date _____