

CONSENT TO TREATMENT AND CLIENT'S RIGHTS

I, _____, signed below, hereby agree that I have entered treatment voluntarily, or I give my consent to a minor or a person under my legal guardianship to enter treatment with Penny Spector-Shleifer, LCSW / therapist (License No. 44SC05672500). The rights, risks, and benefits of treatment have been explained to me.

You have the right to request or to refuse any particular technique or to withdraw from therapy at any time. If you wish to terminate I advise you to discuss it with me prior to termination. You can ask about any alternative treatments and/or training methods available. You may request a referral to another therapist or agency. If you wish to examine your records, you may go over them with me and I will answer any questions you may have. I will ask for your written consent whenever it is necessary to speak or communicate with someone to provide the best possible services to you.

Duration of sessions –Individual Therapy-45 minute and
Couples/Family therapy -50 min.

Treatment-People usually find therapy very helpful, but it does involve some risk. For instance, sometimes when you face difficulties, things may initially seem harder or emotions more intense. In therapy as you work toward a more fulfilling life and you begin to change your thinking, feelings and behavior; you may encounter new challenges and reactions from others. I will attempt to help you deal with these challenges and to manage these risks. I believe that your involvement in therapy is worth the risk for you, but there may be risks that you or I cannot foresee. Please talk about this with me if you have concerns, since you must be the judge about the benefits and risks therapy holds for you.

Privacy and confidentiality: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your consent, usually in writing, except where disclosure is required or permitted by law. As indicated in the HIPAA agreement, suspicion of child abuse, elder / dependent abuse or neglect, and suicidal or homicidal intent are considered required by law to report. Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation or court proceeding, the defendant may have a right to obtain the psychotherapy records and/or testimony by myself (please note that I charge a separate fee for court testimony). In couples and family therapy, or when different family members are seen individually, confidentiality and privilege do not necessarily apply between couples or among family members. I will use my clinical judgment when revealing information.

Confidentiality of e-mail, cell phone, mail, phone and faxes communication: It is very important to be aware that email and cell phone communication can be relatively easily accessed by unauthorized persons, and hence, the privacy and confidentiality of such communication can be compromised. For this reason, I caution you against unsecure email as a means of communication with clients. If I receive an email from you I will respond, but be aware of the consequences, and the fact that another person may read your emails, especially if you email from a work account. You may leave me a confidential voice mail at any time. I check my voice mail during regular business hours, which are Monday through Friday, 9am to 3pm. Please do not use fax, email or voicemail for emergencies.

Emergencies: If there is an emergency during our work together, or I become concerned about your personal safety, the possibility of you injuring yourself or another person, I will do whatever I can within the limits of the law to ensure you receive the proper medical care. For this

purpose, I may also contact the person whose name you have provided on the biographical sheet under the category of "emergency contact".

I consent to treatment and agree to abide by the above stated policies and agreements with the therapist.

_____ signature
Patient name

Date

_____ signature
Patient name

Date

_____ Penny Spector- Shleifer, LCSW