LEHMAN THERAPY

Julie Lehman, MS, LMFT #109200

INFORMED CONSENT

I, ______________________________, agree to participate in individual/group/partner/family (circle one) treatment with my therapist Julie Lehman, MFT #109200

Client's Rights and Responsibilities:

1. You may terminate therapy at any time, but you agree in good faith to communicate with your therapist in order to give advance notice, at least two session notice if possible.

2. Written permission to treat minor children (under 18) will be obtained from parent(s) or legal guardian(s), except when the child is emancipated, when there is a risk of child abuse, when children are a danger to themselves or others, or when a risk may be reduced by immediate treatment.

3. Timely attendance at all schedule appointments and consistent engagement in the therapeutic process is expected.

4. A minimum of 24 hours notice is requested before canceling or rescheduling an appointment. This allows for scheduling other clients during available hours. Full fee will be charged after one "free pass" to cancel within 24 hours per 6mo period.

5. I understand and agree to pay a fee of $______ per session, due at time of service. If my financial situation changes, I will discuss adjusting the fee with my therapist.

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 written consent**. The therapist may be mandated or allowed by law, however, to report the following to the appropriate authorities:

1. **Danger to others**:
- Suspected abuse or neglect of children, elders, or dependent adults.
- If the client threatens harm to another person or his/her/their property. The therapist may be obligated to inform the potential victim if that information is known.

2. **Danger to self**: If the client is in danger of committing suicide.

3. If the client is **gravely disabled**.

Whenever possible, the therapist will inform the client in advance of any intent to report.

Additional exceptions to confidentiality may occur in certain **legal proceedings and emergency situations**.. If you place your mental status at issue in litigation initiated by you, the defendant

may have the right to obtain your psychotherapy records and/or testimony by the therapist.

In **couples/partner or family therapy**, or when multiple family members are seen individually, confidentiality and privilege do not apply between the couple or between family members.

When **minor children** receive treatment with parent/legal guardian consent, parents/legal guardians are the holders of privilege; however the clinician will hold detailed information regarding minor children's treatment.

____

Client name (print) *Signature* *Date*

____

Client name (print) *Signature* *Date*

____

Client name (print) *Signature* *Date*

____

Clinician name (print) *Signature* *Date*

Please initial below to consent to **telehealth services*** (phone, videoconference) as needed during treatment:

________ ________ ________

* This will be employed as needed, confidentiality will be maintained under HIPAA privacy policies using compliant platforms such as Zoom; access care via phone if video fails; if all systems of communication fail and you are in need of urgent support, please utilize after hours resources online.

Please initial here acknowledging receipt of our Privacy Policies ______________

Would you like a copy of this Informed Consent Agreement? Yes / No

If so, please sign acknowledging receipt _______________