Pfeiffer Institute for Marriage and Family Therapy
Informed Consent for Therapy Services

Consent to treatment

I voluntarily consent to receive therapy services and/or to have my child receive services provided at the Pfeiffer Institute for Marriage and Family Therapy. I understand that services will be provided by marriage and family therapists in training under the supervision of program or clinical faculty and staff. I further understand that Pfeiffer University is a teaching program.

I understand that if I miss, reschedule, or cancel appointments to the point of not being seen for 60 days or longer, my case will be considered inactive and will be terminated. I understand that I may resume therapy by calling 704.945.7324.

I understand the purpose and potential benefit of questionnaires, videotaping, live observation, and supervision of my therapy services, and I voluntarily consent and agree to their use. I understand that the Pfeiffer Institute will retain the ownership rights to these digital recordings, which will be used for supervision and educational purposes only. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period outlined in the Pfeiffer Institute's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

I understand that this consent to services will be valid and remain in effect as long as I attend the Pfeiffer Institute for Marriage and Family Therapy unless revoked by me in writing, with written notice provided to the Institute.

I understand that the Pfeiffer Institute may not be used to formally document grievances against Pfeiffer University campus personnel; neither will the Pfeiffer Institute be used as a vehicle to substantiate client testimony in a court of law. No clinical student intern is qualified to testify in a court of law – it is beyond their scope of training. In addition, I agree not to ask the student intern at the Pfeiffer Institute to testify in court, nor will I obtain a subpoena because I understand that by doing so it may harm our professional and therapeutic relationship.

I understand that all communications with the Pfeiffer Institute are confidential and that no information about my sessions will be released without my written authorization and the written authorization of each member in the client system.

I understand that the therapist intern may work with multiple members of my family (e.g., partner, children). In relational cases, the intern 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, to effectively serve the unit being treated. This "no secrets" policy is intended to allow the intern to continue to treat the couple or family 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.

I certify that the handbook, including statements on the limits of confidentiality, has been fully explained to me, that I have read it or had it read to me*, and that I understand its contents. I understand that there are certain occasions when federal and/or North Carolina law or ethical considerations allow or require the disclosure of confidential information to others. Such considerations for disclosure are:

1. North Carolina law and ethical practice requires clinic personnel or PIMFT personnel to notify appropriate state agencies if we suspect or know of a child abuse situation or have cause to believe that an elderly or disabled person is being abused.
2. We may also give case information when a court of law orders the release of information.
3. If there is a threat to harm yourself or another person and the threat is determined to be serious, the therapist may take whatever actions are necessary to protect the person at risk, even if it involves disclosing confidential information. If the therapist assesses that the client has made a serious threat, the therapist may disclose information to law enforcement and/or the intended target of the threat.
4. If I become a civil litigant and use my mental health for a legal claim or defense, the content of my communication may not be protected under these conditions.
5. If I am involved in a serious medical emergency, appropriate information may be given to medical personnel.

I understand that if I make an allegation against the student intern/Pfeiffer Institute, the Pfeiffer Institute has the right to disclose my records in their own defense to the appropriate legal and ethical boards involved.

I understand that upon graduation and passage of the national licensure exam, students are provisionally licensed (for details, see www.nclmft.org). I understand that if I choose to continue therapy with this therapist intern after his/her graduation, s/he will no longer be under the supervision or responsibility of Pfeiffer Institute.

If I have any questions or concerns now or in the future, I understand that I should consult with my therapist or the Clinic Director (704.945.7324).

I understand that I certify that I have legal authority to give consent for the treatment of all minor children that are included in therapy.

I have asked my therapist for any needed clarification of the procedures and conditions mentioned in this consent statement. I am satisfied with the explanations, and agree to abide by the conditions in of this consent form.

☐ I have read or have had this form read* to me and I **AGREE** to receive counseling services.

☐ I have read or have had this form read* to me and I **DECLINE** to receive counseling services.

Also, my signature on this form confirms that I have read, understood, and agree to the policies listed in the Notice of Privacy Practices.

_____
Date

_____	_____	_____
Print Client Name/Legally Authorized Person	Signature	Relationship to Client
_____	_____	_____
Print Client Name/Legally Authorized Person	Signature	Relationship to Client
_____	_____	_____
Print Client Name/Legally Authorized Person	Signature	Relationship to Client
_____	_____	_____
Print Client Name/Legally Authorized Person	Signature	Relationship to Client
_____	_____	
Print Witness/Translator* Name	Signature	