Client #: _____
Date: _____

PFEIFFER INSTITUTE *Reach* MARRIAGE & 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 Pfeiffer Institute *Reach*. 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.

_____ Individual Therapy
_____ Couples Therapy
_____ Therapy of a Minor
_____ Family Therapy

I understand that this is the primary modality of therapy and sessions within this modality will be focused on problems and goals related to this treatment approach. Confidentiality and release of information is based on treatment modality. If treatment modality changes, a new informed consent will be completed and the clinician will discuss this with the client(s). I understand that the therapist intern may work with multiple members of my family (e.g., partner, children). In couple therapy or family therapy 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 understand that this consent to services will be valid and remain in effect as long as I attend Pfeiffer Institute *Reach* unless revoked by me in writing, with written notice provided to Pfeiffer Institute *Reach*.

Confidentiality and Limits of Confidentiality

I understand that therapy and all communication with Pfeiffer Institute *Reach* 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 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. If the client or guardian gives written permission to release information.
2. If we suspect or know of a child abuse situation or have cause to believe that an elderly or disabled person is being abused.
3. If a court of law orders us to release information, we would provide only the case information required by the court, which may include information the client did not consent to be released.
4. If a client talks about harming himself or herself or another person and the threat is determined to be serious, the therapist intern may take whatever actions are necessary to protect the person at risk, even if it involves disclosing confidential information. If a client threatens someone else, the therapist intern may disclose information to law enforcement and/or the intended target of the threat.
5. If a client becomes a civil litigant and uses mental health for a legal claim or defense, the therapy records may not be protected.
6. If a client is involved in a serious medical emergency at Pfeiffer Institute *Reach*, appropriate information may be given to medical personnel.
7. If a client makes allegation against the student intern or clinic, Pfeiffer Institute *Reach* has the right to disclose that client's records in their own defense to the appropriate legal and ethical boards.

Supervision and Recording

I understand the purpose and potential benefit of questionnaires, recording, live observation, and supervision of my therapy services, and I voluntarily consent and agree to their use. I understand that Pfeiffer Institute *Reach* will retain the ownership rights to these digital recordings, which will be used for educational and supervision 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 *Reach* policy. Images

Client #: _____
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that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative. I can contact my therapist intern's supervisor by reaching out to the Clinic Director at 919-941-2900.

What Therapy is Not

- I understand that Pfeiffer Institute *Reach* may not be used to formally document grievances against Pfeiffer University campus personnel.
- Pfeiffer Institute *Reach* cannot be used to substantiate client testimony in a court of law. I understand that therapist interns are not qualified to testify in a court of law; therefore, I agree not to ask a therapist intern or supervisor to testify in court, nor will I obtain a subpoena.
- I understand that therapy is not a custody evaluation or investigation process.
- I understand therapy is not friendship and that therapist interns do not connect with clients on social media. Additionally, gifts and other personal gestures may jeopardize the therapeutic relationship and will be declined.

Policies

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 Pfeiffer Institute *Reach*.

I certify that the Client 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 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 *Reach*.

Signatures

I certify that I have legal authority to give consent for the treatment of all minor children 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 this consent form. If I have any questions or concerns now or in future, I understand I should consult with my therapist or the Clinic Director. I know that I can receive a copy of the AAMFT Code of Ethics upon request.

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

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/Interpreter* Name	Signature	