A. Rachel Weiss, MSW, LCSW
INDIVIDUAL | COUPLE | EMDR THERAPY

Couples Therapy Informed Consent Form

We understand that couples therapy begins with an evaluation of our relationship, past and present. While Rachel Weiss is deciding whether she is the appropriate therapist for us, we will decide whether we wish to begin couples therapy with her. We understand that because of the commitment of time and money, plus the potential impact on us and others (see below), it is important to make an informed choice for a couples therapist.

We have read and understand the potential limits of confidentiality, and we have received a copy to keep.

We understand that information discussed in couples therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners. We agree not to subpoena Rachel Weiss to testify for or against either party or to provide records in a court action. This contract is an agreement between the interested parties that no party shall attempt to subpoena my testimony, or my records, for a deposition or court hearing of any kind for any reason.

All parties acknowledge that the goal of psychotherapy is the amelioration of psychological distress and interpersonal conflict, and that the process of psychotherapy depends on trust and openness during the therapy sessions.

Therefore it is understood by all parties that if they request my services as a psychotherapist, they are expected not to use information given to me during the therapy process for their own legal purposes or against any of the other parties in a court or judicial setting of any kind.

We understand all policies as described on the Professional Disclosure Document and accept them as conditions for entering into couples therapy with Rachel Weiss. We understand the limits and benefits of using insurance to pay for couples therapy. If we use insurance, we agree to provide all information needed to comply with insurance regulations. We understand that if we use insurance, Rachel Weiss will not retain control over information provided to the insurance company.

We have been given the opportunity to ask questions and discuss confidentiality and disclosure policies with Rachel Weiss. We understand that while working as a couple, anything either of us tells Rachel Weiss individually, whether on the phone, or in an individual meeting, may not be held as confidential, and at Rachel Weiss's discretion, may be shared with the spouse/partner during a subsequent couple session.

We agree to share responsibility with Rachel Weiss for the therapy process, including goal setting, and termination. By entering into couples therapy, we accept that we both understand that working towards change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. We understand that the changes one or both of us makes will have an impact on our partner and on others around us. We accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them. *[This is especially true if we have dependent children.]*

Rachel Weiss has explained that if remaining together is harmful to one or both partners, the focus will be on facilitating an amicable separation.

We agree to pay for all services provided by Rachel Weiss, including any charges not fully reimbursed by the insurance company (if applicable). We understand that no insurance company will pay for missed sessions, and we agree to Rachel Weiss's policy of charging the full session fee, if we fail to cancel appointments 24 hours in advance of our scheduled appointment time. In cases of a "no-show," not contacting Rachel Weiss prior to the start of the appointment time, we understand, and agree to Rachel Weiss's policy, of charging the full session fee, with an additional $30 dollars. Our card on file will be charged automatically in such cases.

By signing below, we agree to accept mental health services from Rachel Weiss, and accept full responsibility for payment for such services.

Patient's Printed Name_____ Date_____

Patient's Signature_____Date_____

Patient's Printed Name_____ Date_____

Patient's Signature_____ Date_____