



Catholic Community Services Yuma
Counseling and Behavioral Health Services
Informed Consent to Treatment for Couples or Marriage Therapy

We, _____ and _____, hereby attest that we have
Printed Name of Client *Printed Name of Client*

voluntarily entered into treatment at Catholic Community Services Yuma (CCS Yuma) for couples or marriage therapy. Further, we consent to have treatment provided by a Provider who is either a Social Worker, Counselor, Intern Counselor and/or Support Staff in collaboration with the Clinical Supervisor, Troy Love, LCSW-10449. The Clinical Supervisor can be reached at 928-341-9400.

The rights, risks and benefits associated with the treatment have been explained to us. We understand that the treatment may be discontinued at any time by either party. CCS Yuma encourages that this decision be discussed with the attending Provider. This will help facilitate a more appropriate plan for discharge.

Purpose of Treatment

We understand that couples therapy begins with an evaluation of our relationship, past and present. We understand that because of the commitment of time and money, plus the potential impact on us and others, it is important to make an informed choice on the right Provider for us. Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits, such as, processing negative experiences and/or developing coping skills to help increase the quality of life. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen.

Goals of Treatment and Plans

Current and background information will be collected to help identify our therapeutic needs; this includes identifying a diagnosis. The purpose of the diagnosis is to help develop a plan consistent with your abilities, temperament, development level and circumstances. Psychotherapy requires a very active effort on your part, we agree to share responsibility with our Provider for the therapy process, including goal setting and termination. In order to be most successful, we will have to work on practicing skills outside of sessions. We have the right to set our own goals and develop a Treatment Plan that is consistent with our goals, and counseling services may be provided in an individual, family, group and/or couples basis. Over time our goals may change, as circumstances change. Reviewing our Treatment Plan is something that will be done throughout treatment; according to our treatment needs. Different techniques and models of counseling will be used, according to our treatment goals. We also have the right to refuse any recommended treatment or withdraw consent to treatment. If refusal takes place, we will be advised of the consequences of the withdrawal or refusal.

We understand that therapeutic focus in couples or marriage therapy is on preserving and enhancing the relationship rather than a focus on individual happiness. We also understand that if remaining together is harmful to one or both partners, the focus will be on facilitating an amicable separation.

Notice of Confidentiality and Professional Record Keeping: The confidentiality of client information and records is protected under Federal Regulations and State Law, according to the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. We have the right to request that a copy of your file be made available to any other health care provider at your written request. This request must be submitted in writing and provided to the CCS Yuma Clinical Director. Please refer to your **“Notice of Privacy Practices,”** for additional information. We understand that additional confidentiality practices for couples or marriage therapy will be covered in our **“Confidentiality Contract for Couples or Martial Therapy.”**

Client Responsibilities: As a client in psychotherapy, we have certain rights and responsibilities that are important for us to understand. There are also legal limitations to those rights that we should be aware of and we have corresponding responsibilities to our Provider. Clients have the responsibility to keep their Provider informed of contact information,

changes in condition, voice if they feel the treatment plan needs to be updated, and keep up to date any releases of information.

Client Rights: We understand that as a client of CCS Yuma we I have rights. We have been informed and provided with a copy of the "Client Rights." Any clarifications to these rights can be provided by CCS Yuma. We have the right to decline requests to become a research participant.

Grievance Procedure: We understand that as a client of CCS Yuma we have the ability to submit a complaint/concern, without fear of retaliation or discrimination. We have been informed and provided with a copy of the "Grievance Policy and Procedure." Any clarifications to the procedure can be provided by CCS Yuma.

Non-Voluntary Discharge from Treatment: If a Provider chooses to terminate services before the planned discharge, it is considered involuntary termination. Criteria for an involuntary termination are as follows:

- When a client is no longer willing to participate in his/her treatment plan or work toward agreed upon treatment objectives;
- Upon discovery that a client did not fit the admission criteria or that there were service limitations in the treatment of a particular client & the client would need to be referred elsewhere for services;
- When a client becomes abusive or makes sexual advances towards a counselor or other clients; or
- When a client is no longer compliant with the mandated parameters to treatment &/or re-offends during the course of treatment.

Appointments and Billing: Appointments will ordinarily be 45-50 minutes in duration, and scheduled according to your treatment needs. If you need to cancel or reschedule a session, provide a 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, our policy is to collect the amount of your co-payment [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. Your billing for services received will be consistent with your "**Payment Contract for Services.**"

Use of Technology: "Distance counseling" is a practice not used in place of face-to-face counseling. CCS Yuma does not use cell phones, social media or telemedicine to provide therapeutic or supportive services. Requests for services must be made by calling our office at 928-341-9400 and scheduling an appointment. Technology-assisted services may be used as a reasonable accommodation to provide therapeutic services. If such technology-assisted services are used, the purpose will be explained and possible misconceptions. Technology-based tools to deliver therapeutic services may be used as a part of the therapy process. You have the right to engage in technology-assisted-based services.

Contacting Your Provider: Your Provider may not be immediately available by telephone. At these times, you may leave a message on our confidential voice mail and we will return your call as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from us, or are unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact the Crisis Hotline at 1-866-495-6735, 2) go to your Local Hospital Emergency Room, or 3) call 911. We will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my cases.

Continuum of Services: In the event your assigned Provider is no longer able to continue services, you will be re-assigned another Provider. It will be your choice if you would like to continue treatment services or be referred to another Provider.

Clinical Staffings/Coordination of Care: Your case may be staffed in a group supervision setting for clinical feedback and best practice approach. Your name will not be released.

Parties Acknowledgements – Initial Applicable Areas of Consent

A Provider working under the supervision of a Professional may be required to record sessions as part of their clinical supervision requirements with their education institution and/or the State of Arizona.

_____ I consent to the audio or video recording of sessions for the purpose of quality control and training only and understand
Initial that the recordings will be viewed in clinical supervision prior to the recording being destroyed. I understand and
consent to their destruction following viewing.

Signature of Client/Agent/Representative Date

The Informed Consent has been reviewed with us. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources. By signing below, we agree to accept treatment and accept full responsibility for payment for such services.

_____ I consent to treatment & agree to abide by the above policies and agreements of Catholic Community Services
Initial Yuma.

Signature of Client Date

A Provider working under the supervision of a Professional may be required to record sessions as part of their clinical supervision requirements with their education institution and/or the State of Arizona.

_____ I consent to the audio or video recording of sessions for the purpose of quality control and training only and understand
Initial that the recordings will be viewed in clinical supervision prior to the recording being destroyed. I understand and
consent to their destruction following viewing.

Signature of Client/Agent/Representative Date

The Informed Consent has been reviewed with us. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources. By signing below, we agree to accept treatment and accept full responsibility for payment for such services.

_____ I consent to treatment & agree to abide by the above policies and agreements of Catholic Community Services
Initial Yuma.

Signature of Client Date

Catholic Community Services Yuma Witness:

Witness Printed Name, Position Signature Date