Bay Area Trauma Recovery Clinic

CONSENT TO RECEIVE INDIVIDUAL PSYCHOTHERAPY SERVICES

By signing this form, I the client *(please print your name)* _____ consent to begin receiving psychotherapy services at the Bay Area Trauma Recovery Clinic (BATRC).

Doctoral Trainee Supervision

My therapist will be a doctoral student & trainee enrolled in the Doctor of Psychology program at The Wright Institute, in Berkeley, CA. I understand that my therapist is working under the clinical supervision of a licensed psychologist. If necessary, I may contact my therapist's supervisor directly by calling the BATRC confidential voicemail at (510) 660-1493.

Time-Limited Therapy

My therapist will, under no circumstances, be able to work at the BATRC for longer than the duration of their training year. I understand that my therapy at the BATRC will end, at the latest, in the month of August.

Confidentiality & Exceptions

All of my personal & clinical information that I may share with my clinician & the BATRC will be kept confidential and will not be shared with anyone outside of the BATRC without my written consent. Nevertheless, I am aware that there are a few important exceptions to this confidentiality, and these exceptions are the following:

- *Abuse of a minor*. If I report any situations in which a minor (any person age 17 and younger) is being abused, I understand that my therapist is a mandated reporter who by law will have to make an immediate report to Child Protective Services. Abuse of a minor includes neglect or physical, sexual, or emotional abuse. I also understand that a report will have to be made if a minor (including myself) was abused in the past and the person who committed the abuse still constitutes a risk to other minors.

- *Harm of an elder or dependent adult*. If I report any situations in which an elderly adult or a dependent adult is being harmed, I understand that my therapist is a mandated reporter who by law will have to make an immediate report to the appropriate adult protective services agency. An elderly adult is a person age 65 or older & a dependent adult is a person ages 18 to 64 who has physical or mental limitations that restricts his or her ability to carry out normal activities or to protect his or her own rights. Situations of harm of an elder or dependent adult include physical abuse, abandonment, abduction, isolation, financial abuse, and neglect.

- *Imminent risk of suicide or homicide*. If I report that I am in imminent danger of hurting or killing myself, or of hurting or killing someone else, or of destroying someone else's property, I understand that my therapist is a mandated reporter who is legally required to break confidentiality to protect my own safety as well as the safety of others and their property. My clinician's duty to warn and

protect myself or other people and their property may not only be triggered by my own reports, but also by messages my therapist receives from my immediate family members. In any of these instances, my clinician is allowed to contact the police, my intended victim, my family, or anyone else as necessary.

- *Sexual activities of minors*. Reportable actions also include certain sexual activities of minors, even if the activities are consensual, depending on the minors' age.

- *My therapists' supervision and training*. As part of my therapist's supervision, she or he will be sharing my clinical information with her or his direct supervisor. My therapist's doctoral training also includes additional supervision and case discussions at the BATRC as well as at my clinician's graduate school, where my clinical information may be shared exclusively for consultation or training purposes, always protecting my confidentiality to the extent of the law. My clinician may also discuss my case with other BATRC clinicians and trainers, but only after all of my identifying information has been concealed. I also understand that my case will always be discussed for the purpose of providing me with the most appropriate treatment and the highest quality of care, and that, even when my information is being concealed, I will be treated with dignity and respect.

Communication With My Therapist

In order to streamline communication for scheduling, my therapist will provide me with a Google Voice number that I may use to communicate about scheduling and other logistics. I understand that this voicemail is not a secure means of communication nor HIPAA-compliant.

I agree to solely communicate confidential information with my therapist on the Confidential Clinician Line at 510-323-6897.

I, the client, understand I may not communicate with my therapist via email at any time and agree to communicate with my therapist by telephone.

Understanding of Trauma-Focused Treatment

The BATRC is a treatment clinic primarily focused on the treatment of trauma. I understand that in addressing my trauma, uncomfortable emotions will come up and I am aware that part of my treatment will be addressing my relationship with these emotions. After reviewing the intake my clinician will make treatment recommendations based on my needs; this could include starting with the Emotion Efficacy Therapy group for emotion regulation or referrals to a clinic that would be more suited to support my needs.

Payment for Services

The BATRC is a low-fee, sliding scale clinic, but it is not free. The rendering of clinical services requires that I fulfill my financial obligations to the clinic. The BATRC rates are determined based on guidelines that my therapist has not designed but must follow. My therapist will not receive any financial compensation for the services they may provide me. On this understanding:

1. I agree to pay the sliding scale rate based on my income for each 50-minute therapy session. I understand that if I have a change in my financial situation or a special circumstance I have the option to apply for a fee reduction with the understanding that I will inform my clinician if my financial situation changes again.

2. I agree that **payment is due at each session** and that I do not have the option to be billed for services at the end of the month. I also understand that is not ethical for the BATRC to allow me to accumulate debt. Therefore, if I fail to pay for two sessions, the next session cannot take place until I am able to pay all of my accumulated fees.
3. I understand that the BATRC cannot provide change and I must pay with a credit card, check, or exact change in cash. If I overpay for a therapy session, I understand that change will not be given and that the overpaid amount will be applied as credit for a future therapy session.

Cancellations & No Shows

I agree to provide my therapist with at least 24 hours notice if I need to cancel my appointment and I may be charged the full cost of the session if I cancel less than 24 hours in advance or do not attend a scheduled session**.** Given the low-fee nature of the BATRC, the demand for our therapy services is greater than our ability to provide services to the community. Therefore, missing two consecutive therapy sessions without previously informing my therapist may also lead to termination or postponement of services. Cancelling three consecutive therapy sessions without prior verbal or written agreement with my therapist may also lead to termination or postponement of services.

Research

In addition to providing a community service, the BATRC is intended to support research on psychotherapy, in the hope that effective therapy interventions might thereby be improved, for the benefit of clients. I understand that my therapist may elect to write a paper of the interventions used and results obtained in our therapy work. I understand that if such a report is written my confidential information will be strictly protected.

My Copy of This Consent

I have the right to receive a copy of this consent form and so my therapist will provide me with a copy during our initial intake interview. I can also receive an additional copy at any time simply by asking my therapist.

Receipt of Privacy Information

I have received health information about privacy rights and patient rights (HIPAA).

By signing this form I agree to all of the above and below:

- I must pay for all sessions at the time of service and cannot accrue debt
- If I do not show nor call and miss 2 sessions in a row, my treatment may be terminated or postponed
- If I cancel 3 sessions in a row, without prior agreement with my therapist, my treatment may be terminated or postponed
- If I cancel my session for any reason, I must provide my therapist with at least 24 hours' notice. If I fail to do this or I do not show for a session for any reason, I will be required to pay for that session in full
- I understand that if I arrive to a session 20 minutes late, I can only have a short "check-in" instead of a full therapy session
- I understand that I am required to pay my full fee for each session unless, or until, other arrangements are agreed upon
- I understand my therapist is a doctoral trainee and is under the supervision of a licensed psychologist
- I understand the limits to confidentiality as stated above

- I understand the BATRC is unable to provide me with change if I pay with cash.
- I am aware that my intake clinician will most likely not be my assigned therapist
- I understand uncomfortable emotions will arise during trauma-focused treatment
- **I am aware my intake clinician will make treatment recommendations based on my needs, including starting with the EET group or referrals to a clinic that would be more suited to support my needs**

_____

Client Name & Signature Date

_____

Intake Clinician Name & Signature Date

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Intake Supervisor Name & Signature Date