Bay Area Trauma Recovery Clinic

CONSENT TO RECEIVE GROUP SERVICES

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

I am attending the following group(s) *(please check all that apply):*

☐ **Managing Strong Emotions (Emotion Efficacy Therapy/EET) Group**
In Emotion Efficacy Therapy, clients will learn skills to become more effective in how you respond to your emotions, learning to experience difficult emotions rather than being overwhelmed or controlled by them. EET also helps you identify your core values and learn to act on them in the "moment of choice," rather than acting on what your emotions tell you to do. And, EET will help you learn strategies to dial down your emotions, even when they are very intense. All these skills will empower you to experience and respond to emotions in a way that will help you create a better life.

☐ **Post-Trauma Growth and Wellness Groups**
As you begin to recover from trauma, your life can be about something else. Using an ACT model, this group highlights ways you can grow after trauma. You will learn to act on your values, your deepest truth and wisdom, at every moment of choice. Even if that choice is sometimes hard; even if that choice brings up some of your old trauma pain. You will learn to see moments of choice you face every day that can take your life and your relationships closer or further away from what you most value, what you most care about. You will learn to hear your own deepest truth and wisdom, as well as sources of wisdom that come from your spirituality and/or a higher power. You will learn how to face and accept pain rather than letting it lead you away from what you value, away from your wisdom, away from the life you want to live.

Doctoral Trainee Supervision

My group therapist(s), *(please print name(s))*_____ is/are doctoral student(s) & trainee(s) enrolled in a Doctor of Psychology program at The Wright Institute in Berkeley, CA. I understand that my therapist(s) is/are working under the clinical supervision of a licensed clinical psychologist. If necessary, I may contact my therapists' supervisor by calling the clinic's confidential voicemail at (510) 660-1493.

Time-limited Therapy

My therapist(s) will not be able to work at the Bay Area Trauma Recovery Clinic for longer than the duration of her or his training year. I understand that, at the latest, our therapy at BATRC will end in the month of July of the year _____.

Exceptions to Confidentiality

All of my personal and clinical information that I may share with my clinician and the Bay Area Trauma Recovery Clinic will be kept confidential by my therapists (and their supervisors) and will not be shared with anyone outside of the Bay Area Trauma Recovery Clinic without my written consent. Nevertheless, I am aware of the following important exceptions to this confidentiality rule:

- *Abuse of a minor*. If I report any situations in which a minor (any person age 17 or younger) is being abused 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. Abuse of a minor includes neglect, physical, sexual, and/or emotional abuse.

- *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 is legally required to break confidentiality to protect my own safety as well as the safety of others and their property. An elderly adult is a person age 65 or older and a dependent adult is a person age 18 to 64 who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her own rights.

- *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.

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

Limits to Confidentiality in a Group Setting

I understand that the other members of the group are not therapists and that, while they have a moral obligation to maintain confidential any information shared in this group, they are not legally obligated to maintain the level of confidentiality under which my therapist(s) must work.

Agreement to Maintaining Confidentiality & Refraining from Relationships with Other Group Members

In the interest of my own as well as other group members' therapeutic process and goals, I agree that as long as I am a participant in the group I will:

- (1) Refrain from engaging in any social, professional, personal, or intimate relationships with other group members outside of the group.

- (2) Maintain absolute confidentiality with regards to any information about, or shared by, other group participants, including the fact of their participation in this group.

I understand that breaking these agreements would seriously compromise the privacy of my fellow group members as well as undermine a healthy therapeutic environment. Therefore, I understand that if I were to break these agreements, I may be asked to leave the group. I also understand that in this case I will be treated with dignity and respect, and offered referrals or alternative forms of therapy, if needed or desired.

Payment and Cancellations

The Bay Area Trauma Recovery Clinic 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 she or he may provide me. Understanding this, **for each group therapy session I agree to pay $10 less than my amount for individual sessions according to the sliding scale.**

I understand that payment is due at each session and that I cannot be billed for services at the end of the month. 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. I also understand that the Bay Area Trauma Recovery Clinic cannot provide change and I must pay with a check or exact change in cash. If change is needed when paying in cash, I understand that money will be applied to a future group therapy session.

Attendance

- I understand that I must call group leaders ahead of time when I will arrive late or will miss a group. I can call (510) 660-1493 and leave a voicemail for my clinician.
- I understand that if I miss a session or cancel a session with less than 24 hours notice I am required to pay the full session fee at the next group session.
- I understand that I must pay at every session; including the full fee for missed sessions.
- I understand that I am not allowed to come to group under the influence of substances.
- I understand that if I miss 2 consecutive group sessions, I may be asked to leave the group.
- I understand that attendance to each session is required and that if I miss a total of 3 groups at any point I will be asked to leave the group.
- I understand that I am not allowed to discuss any suicidal or parasuicidal behavior in skills groups.

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

Research

In addition to providing a community service, the Bay Area Trauma Recovery Clinic supports research on psychotherapy, in the hope that effective therapy interventions might be improved, for the benefit of clients. I understand that BATRC therapist(s) may elect to write material intended for publication that describes the interventions used and results obtained in our therapy work. I understand that if such a report or publication is written my confidential information will be strictly protected.

My Copy of this Consent Form

I have the right to receive a copy of this consent form. If I would like a copy, I will ask my therapist to provide me with one. I can also receive an additional copy at any time by asking my therapist.

_____

Client Name & Signature Date

_____

Therapist Name & Signature Date

_____

Group Supervisor Name & Signature Date