ISU-MERIDIAN COUNSELING CLINIC
Department of Counseling  ISU-Meridian
Health Science Center
1311 E. Central Drive
Meridian, ID 83642
(208) 373-1719

AGREEMENT FOR COUPLE/FAMILY THERAPY

I, ______________________________________, the client, agree to meet with the Student Counselor named below at the appointment times and places we agree on, starting on ____________, 20____ for approximately ____________ sessions of ___________ minutes each.

I have read the following materials on the therapy, which have been provided to me by this counselor:

1. [ ] HIPPA Notice of Privacy  2. [ ] Consent to Video Tape  3. [ ] Limits of Confidentiality

I believe I understand the basic ideas, goals, and methods of this counseling. I have no important questions or concerns that the counselor has not discussed. In my own words, I understand the following:

With enough knowledge, and without being forced, I enter into treatment with this counselor. I will keep my counselor fully up to date about any changes in my feelings, thoughts, and behaviors. I expect us to work together on any difficulties that occur, and to work them out in my long-term best interest.

Duration of Treatment: At the end of ____ meetings, we will evaluate progress and may change parts of this agreement as needed. Our goals may have changed in nature, order of importance, or definition. If I am not satisfied by our progress toward goals, I will attempt to make change in this agreement, and I may stop treatment after giving this counselor at least 7 days’ notice of my intentions and meeting with the counselor for one last time.

Fee for Service: This agreement shows my commitment to pay for this counselor’s services. It also shows this counselor’s willingness to use and share his or her knowledge and skills in good faith. I agree to pay in cash or check, $15.00 per session for Individual Therapy/$20.00 Couple/Family Therapy. I understand that payment is due at the beginning of each session. I understand and accept that I am fully responsible for this fee.

Videotaping of Sessions: I also give my permission for the counselor to videotape our sessions for personal review, supervision, and limited educational purposes. All who may view these videotapes are bound by the legal framework of privacy and confidentiality. I understand that any information in this recording that could identify me in any way will not be published or given our without my written consent. I understand that all video recordings of these sessions will be destroyed at or before the conclusion of my counseling with this counselor.

Limitations of Service Provided by ISU-Meridian Counseling Center: I understand that ISU-Meridian Counseling Center is a training facility and therefore some counseling services are not provided. Services not provided include, but are not limited to, issues pertaining to parental fitness and custody, court or legally mandated mental competency evaluation, counseling pertaining or associated with criminal proceedings. Further, I understand that other services may not be provided based on the clinical judgment of my counselor’s supervisor and/or faculty of Idaho State University. I understand that, in the event that such services are required, I will be provided with a list of referrals.

My signature below indicates that I understand and agree with all of the above points.

__________________________________________________________  _______________________________
Signature of client  Date

I, the counselor, have discussed the issues above with the client. My observations of this client’s behaviors and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

__________________________________________________________  _______________________________
Signature of counselor  Date

[ ] Copy accepted by client
[X] Copy kept by counselor
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Signature of counselor                                                            Date

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