*Informed Consent to Psychotherapy**

This form documents that

☐ I, ____ ,

☐ we, ____ ,

____ ,

give our consent and agreement to Sairalyn Ansano, ATR-BC, LCAT ______
(the "psychotherapist") to provide psychotherapeutic treatment to

☐ me.

☐ us.

☐ my/our child, ____ ,
and to include us, the parents, as necessary, as adjuncts in the child's treatment.

While we expect benefits from this treatment, we fully understand that no particular outcome can be guaranteed. We understand that we are free to discontinue treatment at any time but that it would be best to discuss with the psychotherapist any plans to end therapy before doing so.

We have fully discussed with the psychotherapist what is involved in psychotherapy and we understand and agree to the policies about scheduling, fees and missed appointments. We understand that we are fully financially responsible for treatment, which, if we have health insurance, includes any portion of the psychotherapist's fees that are not reimbursed by my insurance. We understand what the frequency of our sessions will be and we understand that we are fully responsible for payment of all deductibles and co-payments if applicable. We understand that payment will be due at the beginning of every session, and that we will be personally responsible for payment in full for any canceled session if we do not give the psychotherapist at least 48 hours advance notice of the cancellation (please note that insurers don't pay for canceled sessions).

Our discussion about therapy has included the psychotherapist's evaluation and diagnostic formulation of our problems, the method of treatment, goals and length of treatment, and information about record-keeping. We have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. We understand that therapy can sometimes cause upsetting feelings to emerge, that we may feel worse temporarily before feeling better, and that we may experience distress caused by changes we may decide to make in our lives as a result of therapy.

We understand that the psychotherapist cannot provide emergency service. The psychotherapist has told us whom to call if an emergency arises and the psychotherapist is unavailable. In any case, we understand that in any emergency, we may call 911 or go the nearest hospital emergency room.

We understand that information about psychotherapy is almost always kept confidential by the psychotherapist and not revealed to others unless we give our consent. There are a few exceptions as follows:

1. The psychotherapist is required by law to report suspected child abuse or neglect to the proper authorities. The psychotherapist is also mandated to report to the authorities patients who are at imminent risk of harming themselves or others for the purpose of those authorities checking to see whether such patients are owners of

www.sairalyn.com
studio@sairalyn.com

225 W 35th Street, 7th fl.
New York, NY 10001

(646) 801-4724

firearms, and if they are, or apply to be, then limiting and possibly removing their ability to possess them.

2. If one of us tells the psychotherapist of an intention to harm another person, the psychotherapist must try to protect the endangered person, including by telling the police, the person or other health care providers. Similarly, if one of us threatens to harm ourselves, or our life or health is in any immediate danger, the psychotherapist will try to protect us, including, as necessary, by telling others such as relatives, the police and other health care providers, who can assist in protecting us.

3. If we are involved in certain court proceedings the psychotherapist may be required by law to reveal information about our treatment. These situations include child custody disputes, cases where a therapy patient's psychological condition is an issue, lawsuits or formal complaints against the psychotherapist, civil commitment hearings, and court-ordered treatment.

4. If our health insurance or managed care plan will be reimbursing us or paying the psychotherapist directly, they will require that we waive confidentiality and that the psychotherapist give them information about our treatment.

5. The psychotherapist may consult with other psychotherapists about our treatment, but in doing so will not reveal our names or other information that might identify us unless specific consent to do so is obtained. Further, when the psychotherapist is away or unavailable, another psychotherapist might answer calls and so will need to have some information about our treatment.

6. If our account with the psychotherapist becomes overdue and responsible parties do not pay the amount due or work out a payment plan, the psychotherapist will have to reveal a limited amount of information about a client's treatment in taking legal measures to be paid. This would include our name(s), social security number(s), address, dates and type of treatment and the amount due.

In all of the situations described above we understand that the psychotherapist will try to discuss the situation with us, or notify us, before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

If the parents and child are participating in a managed care plan, the parents have discussed with the psychotherapist their financial responsibility for co-payments, and the plan's limits on the number of therapy sessions. The psychotherapist has also discussed options for continuation of treatment when managed care or health insurance benefits end. If the parents are not participating in a managed care program, they understand that they are fully financially responsible for treatment, including any portion of the fees not reimbursed by health insurance.

We understand that we have a right to ask the psychotherapist about the psychotherapist's training and qualifications and about where to file complaints about the psychotherapist's professional conduct.

By signing below we are indicating that we have read and understood this agreement, that we give our consent to treatment, and that we have the proper legal status to give consent to therapy.

____	____________________
Signature	Date

____	____________________
Signature	Date

www.sairalyn.com
studio@sairalyn.com

225 W 35th Street, 7th fl.
New York, NY 10001

(646) 801-4724

Informed Consent Addendum to Child Psychotherapy

The parents, as legal guardians of the child, have rights to general information about what takes place in the child's therapy, to information about the child's progress in therapy, to information about any dangers the child might present to self or others, and, upon request, to obtain copies of the child's treatment record (with certain qualifications and exceptions). The parents understand that it is usually best not to ask for specific information about what was said in therapy sessions because this might break the trust between the child and the psychotherapist, especially for children over the age of 12.

The parents agree that in the event custody of, or visitation with, the child is contested in a legal proceeding, neither the parents nor their attorneys will require the psychotherapist to testify at any of the proceedings, because to do so would hurt the child's treatment, because the psychotherapist's role is a therapeutic and not evaluative one, and because other forensic professionals would be better able and more appropriate to conduct any necessary evaluation. Because of these limitations, the psychotherapist also will not be able to give any opinion regarding custody, visitation or any other legal issue. If such a proceeding does occur, the parents agree that the psychotherapist's role will be limited to providing to a mental health professional appointed to perform such an evaluation, and/or to the attorneys, law guardian, if any, and the judge involved in the legal proceeding, written information regarding, and/or the record of, the child's treatment; the psychotherapist will provide these either as required by law or upon the authorization of either parent.

The psychotherapist has explained to the parents that children with two parents have the best chance to benefit from therapy if both parents are involved and cooperate with each other and the psychotherapist. If both of a child's parents are consenting to therapy:

- Each of us agrees that he or she will not end the child's therapy without the agreement of the other parent, and that if we disagree about the child's continuing in therapy, we will try to come to an agreement, by counseling if necessary, before ending the child's therapy.
- We each agree to cooperate with the treatment plan of the psychotherapist for the child and understand that without mutual cooperation, the psychotherapist may not be able to act in the child's best interests and may have to end therapy.
- We agree that each of us has and shall continue to have the right to information about the child's treatment and to the treatment records of the psychotherapist regarding the child, and agree that the psychotherapist may release information or records to either of us without any additional authorization of the other.

____
Full Name of Print/Guardian (PRINT)

____ _____________________
Signature *(of parent/guardian)* Date

____
Full Name of Parent/Guardian (PRINT)

____ _____________________
Signature *(of parent/guardian)* Date

____
Full Name of Child (PRINT)

____ _____________________
Signature *(of child over 12 years of age)* Date

www.sairalyn.com
studio@sairalyn.com

225 W 35th Street, 7th fl.
New York, NY 10001

(646) 801-4724

Informed Consent Addendum to Couple or Family Psychotherapy

We understand that, except in exceptional circumstances, the psychotherapist cannot keep secrets from other family members who are involved in the therapy because this might harm the person who does not know.

We agree that each of us has and shall continue to have the right to information about our individual and conjoint treatment sessions, and to the treatment records of the psychotherapist regarding our individual and conjoint treatment sessions. We each agree that the psychotherapist may release such information or records to either or all of us without any additional authorization(s) of the other(s). We understand that each of us will not, however, have any right of access to information or records regarding individual treatment sessions of other family members.

We agree that if marriage or parenting problems lead to legal disputes over child custody or visitation, neither of us will ask nor require that the psychotherapist testify regarding custody or visitation. If a custody or visitation proceeding does occur, we agree that the psychotherapist's role will be limited to providing to a mental health professional appointed to perform a forensic evaluation, and/or to the attorneys, law guardian, if any, and the judge involved in the legal proceeding, written information regarding, and/or the record of, our treatment; the psychotherapist will provide these either as required by law or upon our authorization.

____
Full Name (PRINT)

____ ________________________
Signature Date

____
Full Name (PRINT)

____ ________________________
Signature Date

____
Full Name (PRINT)

____ ________________________
Signature Date

www.sairalyn.com
studio@sairalyn.com

225 W 35th Street, 7th fl.
New York, NY 10001

(646) 801-4724

Informed Consent Addendum to Group Psychotherapy

I understand that the psychotherapist cannot assure me that other group members will keep confidential what is said in the group therapy sessions. I assume that risk and understand that the psychotherapist cannot be held responsible for other group members revealing confidential information. There are rules, however, that are meant to protect confidentiality. These rules, which I agree to follow, are:

1. Only first names will be used at group sessions.
2. I will not socialize with other group members outside of sessions.
3. I will not discuss any information about a group member except with other group members during therapy sessions.
4. There will be no visitors at, or recordings of, group sessions allowed.
5. For breaking any of these rules, I can be expelled from the group or required by the group to pay a fine to the person(s) I hurt by breaking a rule, and understand I could even be subject to a lawsuit by that person.

____
Full Name (PRINT)

______________________________________ ____________________
Signature Date

www.sairalyn.com
studio@sairalyn.com

225 W 35th Street, 7th fl.
New York, NY 10001

(646) 801-4724

Consent for Use of Artwork*

We, the undersigned, authorize that artwork created during our art therapy sessions may be photographed or photocopied for reproduction.

We choose the following areas of use for our artwork:

☐ Scholarly or educational publication

☐ Promotional materials (brochures, website, PR, consumer publications)

☐ Academic presentations

We understand that use of the artwork released is confidential and that appropriate steps shall be taken to protect our identity and to disguise any part of the art piece which might reveal our identity. We also understand that we have the right to cancel our permission to use the artwork before it is released.

☐ We do not give permission for our art to be used in any manner outside of our confidential therapy sessions.

____
Full Name (PRINT)

_______________________________________ ____________________
Signature Date

____
Full Name (PRINT)

_______________________________________ ____________________
Signature Date

____
Full Name (PRINT)

_______________________________________ ____________________
Signature Date

www.sairalyn.com
studio@sairalyn.com

225 W 35th Street, 7th fl.
New York, NY 10001

(646) 801-4724

Consent for Release of Confidential Information*

Client Name(s): ____

____

Released to: Sairalyn's Studio
204 Princeton Avenue
Jersey City, NJ 07305

From: ____

____

Extent or Nature of Information to be Disclosed:

Assessment, medical evaluation, and clinical impressions.

Purpose or Need for Information:

Treatment planning and coordination of services.

We, the undersigned authorize the release of information from my records, we understand that the information to be released is confidential and protected from disclosure and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on our part. We also understand that we have the right to cancel my permission to release information at any time before it is released. We also understand that our consent to release will expire in 120 days from this date if not acted upon prior to that time.

____
Full Name (PRINT)

____ _______________________
Signature Date

____
Full Name (PRINT)

____ _______________________
Signature Date

____
Full Name (PRINT)

____ _______________________
Signature Date

www.sairalyn.com
studio@sairalyn.com

225 W 35th Street, 7th fl.
New York, NY 10001

(646) 801-4724