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**INFORMED CONSENT**

As a Licensed Marriage and Family Therapist, Dr. Angel Colamussi is governed by certain laws and regulations and by code of ethics for the profession. This ethics code requires that you are made aware of certain office policies that may affect you. Please take the time to read the following information

**Confidentiality**

Under the law, what you reveal to your counselor is legally “privileged communication.” You must sign a written release before any information about you or your treatment can be disclosed. The following are exceptions to the general rules regarding your confidentiality:

State laws mandate that psychotherapists report all incidents of actual or suspected child abuse or neglect, elder abuse, and dependent adult abuse. The law also requires that incidents of threatened harm to self or others be reported.

If you are a minor, we are required to answer questions your parents or guardians might have about your progress. We do not have to reveal the details of what is said during your sessions unless we have a concern about someone’s safety.

**If you are the guardian of a minor or are a minor, please read the following**

By signing below, I give my consent for Dr. Angel Colamussi to conduct therapy sessions with the minor listed below. I have also been informed of the limitations to confidentiality in terms of the treat to me about certain topics such as substance use and sexual activity. I accept Dr. Angel Colamussi’s judgment in regards to releasing information related to the treatment of this minor. In addition, I understand that at anytime if Dr. Angel Colamussi believes this minor is in danger of hurting him or herself, I will be notiﬁed immediately.

**Couples and Families Limitations to Confidentiality**

This written policy is intended to inform you, the participants in therapy, that when your therapist agrees to treat a couple or a family, they consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, your therapist will seek the authorization of all members of the treatment unit before they release confidential information to third parties.

During the course of a therapists work with a couple or a family, they may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that your therapist is doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with your therapist, please understand that generally these sessions are confidential in the sense that your therapist will not release any confidential information to a third party unless required by law to do so or unless your counselor has your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, your therapist would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, your therapist may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if your therapist is to effectively serve the unit being treated. Your therapist will use their best judgment as to whether, when, and to what extent they will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure**.** Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow your therapist to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If your therapist is not free to exercise their clinical judgment regarding the need to bring this information to the family or the couple during their therapy, your therapist might be placed in a situation where they will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the \_\_\_\_\_\_\_\_\_\_\_\_\_(couple/family or other unit) being seen, acknowledge by our individual signatures on this informed consent that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Dr. Angel Colamussi, and that we enter couple/family therapy in agreement with this policy.

**Appointment Scheduling and Cancellation Policies**

If you are unable to attend your scheduled appointment, you must call at least 24 hours notice in advance, or you will be charged a full session fee. Please understand that your insurance company will not pay for missed or cancelled sessions.

**Therapist Availability/Emergencies**

Telephone consultations between office visits are welcome. However, Dr. Colamussi will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions. You may leave a message for your Dr. Colamussi at any time on his/her confidential voicemail. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance, or the 24 hour emergency crisis line at 888-724-7240.

**Therapist Communications**

Dr. Angel L. Colamussi may need to communicate with you by telephone, mail or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

**My therapist may:**

\_\_\_\_ call me at my home. \_\_\_\_ call me on my cell phone. \_\_\_\_ call me at work. \_\_\_\_

\_\_\_ communicate with me by email. \_\_\_ send a fax to me. \_\_\_ send mail to my home address

Email communication is for non-emergencies only. Email is not a confidential medium of communication and is used only for appointment changes, referrals and non-clinical questions. If you are canceling an appointment with less than 24 hours notice, please call my business number.

**Termination of Therapy**

You may discontinue therapy at any time. If you or Dr. Colamussi determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

**Litigation Limitation**

Dr. Angel L. Colamussi does not do court work. If you need these services referrals to forensic professionals will be provided for you. Our desire is to protect your psychotherapy from the intrusiveness of legal proceedings. By signing this form, you are agreeing that neither you nor your attorney will call us to testify in court or any other legal proceedings, nor will a disclosure of psychotherapy records be requested for legal proceedings.

**Consult for EFT Live and Group**

In order to provide the best possible therapy treatment for you and your family, it is common for Dr. Angel L. Colamussi to participate in consultation and training groups with seasoned mental health professionals on a regular basis. At some point in treatment, you may be asked to participate in a therapy session which will be observed by a live consultation and/or training group.

If you give consent, during these consultation and/or training groups, Dr. Angel Colamussi will present your case(s) to the group via audio or videotape. Typically, a ten-minute segment of your confidential session will be shared with the group, along with a summarization of the presenting problem(s) and relationship history. Absolutely, no identifying information is presented to the consultation and/or training group members. After the case has been presented, the professionals in the group will collaborate with Dr. Angel Colamussi on how to best work with the presenting relationship dynamics. Dr. Angel Colamussi will take record of the feedback and recommendations and will then review this information with you at your next session. Dr. Angel Colamussi will notify you ahead of time if this is going to happen so that you have the opportunity to revoke consent after the session(s) have been recorded.

The mental health professionals in the consultation and/or training group must follow the same confidentiality guidelines as Dr. Angel Colamussi. If by chance someone in the consultation or training group was to know you or a member of your family, they will be asked immediately to leave the group and will not be permitted to participate in the portion of the meeting involving your case. Your case information and the copy of your recorded session will remain with Dr. Angel Colamussi and will not be reproduced or shared at any point. Once the review has taken place, your session file and/or DVD copy of your session will be deleted permanently.

By initialing below, I give my consent to allow a small, designated segment of my confidential therapy session(s) with Dr. Angel L. Colamussi to be:

a) Observed by an EFT live consultation and/or training group with minimal background relationship and clinical history revealed.

b) Recorded via video or audio tape and used for Angel Colamussi’s review only.

**Fee Acknowledgement**

The undersigned, by providing his/her signature in the space below agrees to accept the therapy services provided by Dr. Angel L. Colamussi in accordance with and pursuant to the terms and conditions set forth herein.

The fee for your initial evaluation has been set at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Subsequent treatment provided by the above mentioned names, will be billed at a rate

of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per 50 minute session. If your session goes longer than an hour or if you are participating in intensive therapy, your fee for this service will be negotiated with your therapist and the amount agreed will be charged to you card at the end of each therapy session. All fees are expected to be paid at the end of your therapy session.

I am also authorizing Dr. Angel L. Colamussi to charge me if I do not show up for my scheduled appointment or if I cancel in less than 24 hours notice. The charge for a “no show or late cancellation” is the same as a full session fee.

Dr. Angel L.Colamussi reserves the right to refuse service to any patient on the account of any delinquent or unpaid fees for services performed without any liability or further obligation to the undersigned.

**The undersigned understands and agrees to be bound to such agreements as outlined in this document. Please provide your signature below. If there is more than one adult participating in treatment, both must sign below.**

PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_