Old & New Tables Counseling & Consulting, LLC

2300 Montana Ave, Suite 534

Cincinnati, OH 45211

 513-817-3727

**Informed Consent for Psychotherapy**

**General Information**
The therapeutic relationship is unique in that it is highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing at the end of this document.

**About the Therapist**
I practice as a licensed professional clinical counselor and received my MA in Mental Health Counseling from the University of Cincinnati in 2016. I am currently enrolled in the University of Cincinnati PhD program for Counselor Education & Supervision in addition to the California Institute of Integral Studies graduate certificate program for psychedelic-assisted therapies and research. I draw on several theories within my practice, primarily existential-humanistic, Internal Family Systems, Eye Movement Desensitization and Reprocessing, and frequently utilize mindfulness-based interventions with my clients. I primarily work with adults and am experienced in treating with post-traumatic stress disorder, depression, and anxiety, particularly with members of the LGBTQ+ population.

**The Therapeutic Process**
You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

**Confidentiality**

The session content and all relevant materials to the client’s treatment will be held confidential in accordance with the Health Insurance Portability and Accountability Act unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are described in the Notice of Privacy Practices.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

**Fees & Payment Options**

I charge between $50-$125/hr for therapy services based on a sliding scale, payable by cash, check, or credit/debit card. Payment is due at the time of service. There will be a $30 fee for returned checks. I am happy to offer pro-bono services upon request, though there may be a waiting period for these services. I do not accept insurance. Additional fees may be charged for letters, appearance in court, reports, and extended phone calls.

**Confidentiality and Minors**

As a parent or legal guardian, you have the right to know what your child is bringing up in therapy and to access their private health information. While this is the case, I encourage parents and guardians to use these rights sparingly as doing so may greatly inhibit your child's willingness to share and participate in therapy. Should your child share information with me related to physical or sexual abuse, neglect, or which indicates significant risk for immediate harm to themselves or others, I will let them know of my need to bring this information to your attention.

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**Minor’s Name Minor’s Date of Birth Relationship to Minor**

Please let me know any relevant issues pertaining to custody arrangements or other issues which may impact the relationship between your child and other their other caregiver(s):

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BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

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Name Date of birth

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Signature Date