Voluntary Consent/Notice of Confidentiality for participants of The Christian Method

Kimberly Christian, LCSW-S, BCFBCC, CBT

kimberly@kimberlychristianlcswconsulting.com

I, _____(the client), the undersigned, hereby attest that I have voluntarily entered into this program, with Kimberly Christian, LCSW (the clinician/ psycho-educator). The rights, risks and benefits associated with the program have been explained to me verbally and/or in writing. I acknowledge that I enter into the program hub, community Facebook group, and group accountability calls of my own free will and will share my information as I feel comfortable knowing how confidentiality will be handled in this environment.

Non-Voluntary Discharge:
I understand that I can be discharged from the program group(s) if:
A) I, the client, engages in any group dialogue that is threatening, bullying, or would compromise the confidentiality of any other group members
B) I, the client, refuse to comply with stipulated program rules or policies
C) I, the client, do not make payment or payment arrangements in a timely manner. I (the client) will be notified of the non-voluntary discharge and will not be granted a refund for any remaining time in the program.

Client Notice of Confidentiality: The confidentiality of the identity and/or other personal information shared by members in a group session is maintained and protected and not to be disclosed to outside parties. By voluntarily entering into one of the accountability groups offered in this program I, (the client) understand that although all participants are informed of the confidentiality agreement to maintain privacy within the group, total confidentiality is waived while participating in a group.
I recognize that I may disclose confidential information inside the group at my own discretion, I also realize others will do the same.
I shall keep the identity of other personal information shared as confidential and protect both outside of the group. I will not disclose to any parties outside of the group.
I also acknowledge that I am discouraged from making outside contact with any other program participants but will do so at my own risk.
I (Kimberly Christian, LCSW) will be complying to the HIPPA/PHIPA confidentiality regulations and will not discuss anything shared in any group sessions, webinars, or other contact made with anyone else. The information shared by each client will be protected and used for the sake of the program and any events, transactions, or related forms of interest to the client. Client information will not be sold to a third-party vendor or marketed in any manner.
If you decide to share your program testimony or feedback, which is encouraged, you will be asked to state whether you want your feedback shared anonymously or with your first name only.

When program fees are not paid in a timely manner, according to what is agreed upon at the time of admission, a collection agency may be given appropriate billing and financial information about the participant.
Refunds are not granted within this program. All concerns are to be discussed with the Clinician to seek a remedy.

My signature below indicates that I have been provided with the program policies, terms, and agreements and I consent to participate for the duration of this program with Kimberly Christian, LCSW, providing psycho-educational material. Material will be non-prescriptive and non- therapeutic, and only recommendations will be offered. As this is a non-clinical relationship and the direct care model will not apply, resources may be provided as determined through program interactions or at the request of the participant. Any resources will be generic in nature, based on demographic and suggested professional specialty.

Participant Name (please print) _____Date _____

Participant Signature _____ Date _____

Professional Disclosure Statement

The Christian Method

Kimberly Christian, LCSW-S, BCFBCC, CBT

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Qualifications: I am a Licensed Clinical Social Worker. I am licensed in the state of Texas. Although psychoeducation may be provided through my program to residents within the United States, please note that I am not authorized to provide direct care or counseling suggestions of any type to those outside of Texas. This program is exclusive to those living within the US only.

Disclaimer: The information in The Christian Method is intended solely to provide general education for the personal use of the client, who accepts full responsibility for its use and releases The Christian Method from all liability. This program does not engage in rendering clinical or prescriptive counsel or advice. As such it should be used as an enhancement to other personalized therapeutic services, not used as a substitution.

INFORMED CONSENT

Professional Relationship: Although the education I provide may be very intimate psychologically, our relationship is a professional one rather than a social one. Our contact will be limited to group and live sessions while participating in this program.

Expectations of the Program: While benefits are expected from participating in this program, specific results are not guaranteed. The psychological, philosophical, and theological information offered in the program will lead to personal exploration and could also lead to major changes in your life perspective and decisions you make. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. It will be recommended to anyone seeking more individualized attention or guidance to seek outside therapeutic support in your region and area of need.

Participant Rights: As a participant in this program, you are in complete control of the degree in which you engage in the program. It is recommended to gain the most benefit that you:

i) Complete the 16-week program.
ii) Listen as often as needed to retain the information.
iii) Attend the groups and live sessions.
These are offered to aid in accountability towards your work and will provide an outlet to ask questions and gain support from other members engaged in the same program.

Completion of this program will equip you with skills and techniques proven to reduce symptoms of depression and anxiety most associated but not limited to Major Depressive Disorders, Generalized Anxiety Disorders (including Obsessive Compulsive Disorder), BiPolar Disorders, Post Traumatic Stress Disorder, as well as aid in the health and management of certain Personality Disorders.

My services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please notify me in person or in writing and I will work with you to resolve your concerns to the best of my ability and to your satisfaction.

Referrals: If needed for any reason, I will provide referrals to address any needs you share in group sessions. You will be responsible for contacting and evaluating those referrals and/or alternatives.

Records and Confidentiality: Most of our communication is confidential, but the following limitations and exceptions do exist: 1) I determine you are a danger to yourself or others; 2) you disclose current abuse, neglect, or exploitation of a child, elderly, or disabled person or express the likelihood of committing such abuse 3) I am ordered by a court of law to disclose information.

Client Rights:
Complaints: If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report any complaints to:
Texas State Board of Social Worker Examiners
Complaints Management and Investigative Section, P.O. Box 141369
Austin, Texas 78714 or by calling 800-942-5540.

Civil Rights: Your civil rights are protected by federal and state laws.

Medical/Legal Advice: You may discuss your treatment with your doctor or attorney.

Your rights to receive information:
Termination of services: I have informed you as to what behaviors or violations could lead to termination of services with me.

Confidentiality: You have been informed of the limits of confidentiality and how the information you provide to me upon inquiry or registration will be used for my business purposes, to be able to provide information to you in the program, as well as information on upcoming events or other things that could be of interest to you. Your information will not be sold to a 3rd party vendor or anyone else for that matter.

Policy changes: You will be informed in writing of any policy changes.

Client responsibilities:
You are responsible for your financial obligations.
You are responsible for following the policies.
You are responsible to other clients to act in a way that is respectful, in which their rights are not violated.
You are responsible for providing accurate information about yourself.

By my signature below, I am indicating that I have read and understood the guidelines and policies of The Christian Method. Any questions I had about guidelines or policies for this program have been answered to my satisfaction.

Client Name (please print)_____ Date_____

Client's Signature _____ Date_____

Telehealth/Confidentiality Consent for participants of

The Christian Method

Kimberly Christian, LCSW-S, BCFBCC, CBT

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Telehealth refers to supportive services provided by any means other than a face-to-face visit. Online contact is offered in this program as a means of support between the above-mentioned clinician to The Christian Method program participants.

I hereby consent to participate in telehealth with, Kimberly Christian, LCSW-S, as an offered support element to the program.

I understand that telehealth is the practice of delivering psychoeducational services via technology assisted media or other electronic means between the clinical creator of the program and participants who are in two different locations.

I understand the following with respect to telehealth for this purpose:

- I understand that the relationship I have with the clinician leading the program group sessions is educational in nature only. I am not engaging in a therapeutic relationship and am aware if I present the need for individual therapeutic services, I may be referred to appropriate providers in my area.
- I have the right to withdraw from group participation at any time without affecting my right to continue in the program or receive other benefits to which I would otherwise be entitled.
- There are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- All information disclosed within group meetings is to remain confidential and participant specifics will not be disclosed to anyone outside of the group. I recognize I may disclose confidential information personally inside the group and realize others may do so as well.
- If I express suicidal or homicidal thoughts in a group meeting, am actively experiencing psychotic symptoms or experiencing a mental health crisis, I am aware the group meeting will not properly assess for such symptoms. I need to communicate with my outpatient providers or be aware that any real concern this clinician has will be addressed properly per the guidelines of the Board of Social Worker Examiners.
- During a live session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the group. If you are unable to reconnect, there will be a recorded version of what the clinician shared made available to the group members.

By signing below, I agree to abide by the guidelines and policies of the program.

To the extent permitted by law, I agree to waive and release this provider and her practice from any claims arising from or related to the telehealth session.

_____ _____

Participant Signature/Printed Date