INFORMED CONSENT TO GROUP PSYCHOTHERAPY

This form documents that I,_____, give my consent to Christine Colavito, LMHC, CASAC, (the "psychotherapist") to provide group psychotherapeutic treatment to me.

While I expect benefits from this treatment, I fully understand that no particular outcome can be guaranteed. I understand that I am 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.

I have fully discussed with the psychotherapist what is involved in group psychotherapy and I understand and agree to the policies about scheduling, fees and missed appointments. I understand that I am fully financially responsible for treatment, which, if I have health insurance, includes any portion of the psychotherapist's fees that are not reimbursed by my insurance. I understand that the frequency of group sessions will be _____, that I am fully responsible for payment of all deductibles and co-payments if I have health insurance, that the frequency of payment will be weekly.

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

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

I have received a HIPAA Notice of Privacy Practices from the psychotherapist. I understand that information about psychotherapy is almost always kept confidential by the psychotherapist and not revealed to others unless I give my consent. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Details about certain of those exceptions follow:

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

2. If I tell the psychotherapist I intend to harm another person, the psychotherapist must try to protect that person, including by telling the police or the person or other health care providers. Similarly, if I threaten to harm myself, or my life or health is in any immediate danger, the psychotherapist will try to protect me, including by telling others such

as my relatives or the police or other health care providers, who can assist in protecting or assisting me.

3. If I am involved in certain court proceedings the psychotherapist may be required by law to reveal information about my 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 my health insurance or managed care plan will be reimbursing me or paying the psychotherapist directly, they will require that I waive confidentiality and that the psychotherapist give them certain information about my treatment.

5. The psychotherapist may consult with other therapists about my treatment, but in doing so will not reveal my name or other information that would identify me. Further, when the psychotherapist is away or unavailable, another therapist might answer calls and so will need to have access to information about my treatment.

6. If my account with the psychotherapist becomes overdue and I do not work out a payment plan, the psychotherapist will have to reveal a limited amount of information about my treatment in taking legal measures to be paid. This would include my name, patient identification number, address, dates and type of treatment and the amount due.

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

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.

If I am participating in a managed care plan, I have discussed with the psychotherapist my financial responsibility for any deductible or co-payments, or both, and the plan's limits on the number of therapy sessions. I have discussed with the psychotherapist my options for continuation

of treatment when my managed care benefits end.

I understand that I 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 I am indicating that I have read and understood this form and that I give my consent to treatment.

Signature:_____Date:_____

(of patient or person authorized to consent for patient)