The Family Place

(*Fostering Wellness & Wholeness*)

(THERAPY AGREEMENT FORM)

CLIENT NAME_____ (printed name please)

PLEASE READ CAREFULLY

The Family Place is a mental and behavioural health centre committed to fostering wellness and wholeness in all individuals. We offer counselling and psychotherapy services for children, adolescents, adult individuals, couples and families.

The staff consists of psychologists and other qualified mental health professionals. We attempt to employ the most effective and efficient therapeutic approaches and techniques. Our approach to therapy emphasizes the importance of relationships, especially family relationships, in the process of change. Family members are encouraged to participate. On occasion, family members may experience some uneasiness or discomfort. Please understand that this may be necessary as part of making positive changes.

CONFIDENTIALITY: In general, the confidentiality of all communications between a client and a therapist is protected by law, and information cannot be released without your written permission. However, there are some exceptions:

- Under certain circumstances your file or therapist can be subpoenaed by attorneys or the courts.
- In accordance with ethical codes of mental health professionals, confidentiality does not include information about child abuse/neglect, sexual exploitation by other mental health professionals, elder abuse, or behaviour or threats to harm self or others.
- Any report of injury or suspected injury to a child must be reported to the proper authorities. Parents of minors will be informed of any life threatening activity.
- If communication with other persons requires a copy or copies of your records a fee may be assessed for this service.

Please discuss with your therapist any questions or concerns you may have regarding the limits to confidentiality.

APPOINTMENTS: Since we operate on an appointment basis, your appointment time and office space is reserved exclusively for you at the specified time. It is important that you notify the receptionist or your therapist 6-24 hours in advance if it is necessary to cancel or change your appointment. Failure to do so will result in the client forfeiting the fee for the session as if the appointment were kept.
Failure to do so a second time may result in a referral to another service. If you are more than 15 mins late, we will have no choice but to reschedule your appointment and the fee for the session will be forfeited. If there be a lack of correspondence on your part for a period of at least one month, the therapy agreement will be terminated and any unused session fee will be forfeited.

SESSIONS: (Individual, Couples, or Family therapy): Individual sessions are 45 minutes long, while Family and Couple therapy sessions are 75 mins long. In most cases, you will have a regular time and day weekly when you see your therapist. If no therapy session occurs for a month or more, your case will be closed. We welcome and expect your active involvement in your therapy**.**

ELECTRONICALLY MEDIATED PSYCHOTHERAPY: Because of the nature of email, real-time chat, phone therapy, and video-conferencing TFP cannot guarantee the privacy of these communications. Therefore clients acknowledge the potential risk to confidentiality inherent in the use of these technologies.

FEES: We are committed to providing quality services at a very affordable rate. We also believe in the importance of clients investing in therapy in order to gain the most from it. The fee for a session is N20, 000. Please discuss any fee questions, needs, or problems with your therapist.

BILLING & PAYMENTS: You will be expected to pay for each session upfront, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested or recommended.

SERVICE EVALUATION: After therapy has ended would you be willing to assess our services through e-mail?
CONTACT VIA EMAIL: Y / N (please circle) EMAIL ADDRESS:
_____

CONSENT FOR THERAPY: Please sign below, indicating that you have read and understand these procedures and policies, and that you agree to them and give your consent for therapy. If you have any questions please discuss them with your therapist BEFORE you sign. Thank you for your confidence in our services.

Client signature _____ DATE_____