Farris Counseling Services, LLC

Agreement for Couples Therapy

We, _____ & _____, the clients, agree to meet with the therapist named below at the appointment times and places we agree on, starting on _____, 20___ for about _____ sessions of 45 minutes each.

We have read the following materials on therapy, which have been provided to us by this therapist:

1. Limits of the Therapy Relationship: What Clients Should Know

2.What You Should Know About Confidentiality in Therapy

3.Client Bill of Rights

4. What you should know about managed care and your treatment

We believe we understand the basic ideas, goals, and methods of this therapy. We have no important questions or concerns that the therapist has not discussed.

We understand that reaching these goals is not guaranteed.

We understand that we will have to do the following things/take the following actions: be consistent to appointments, follow-thru on homework assignments, and periodically evaluate the effectiveness of therapy for us as a couple.

With enough knowledge, and without being forced,we enter into treatment with this therapist. We will keep our therapist fully up to date about any changes in our feelings, thoughts, and behaviors. We expect us to work together on any difficulties that occur, and to work them out in our long-term best interest.

At the end of meetings, we will evaluate progress and may change parts of this agreement as needed. Our goals may have changed in nature, order of importance, or definition. If we are not satisfied by our progress toward goals, we will attempt to make change in this agreement, and we may stop treatment after giving this therapist at least 7 days' notice of our intentions and meeting with the therapist for one last time.

This agreement shows our commitment to pay for this therapist's services. It also shows this therapist's willingness to use and share her knowledge and skills in good faith. I agree to pay $ _*copay*__ per session, and to pay at the end of each session. We agree to pay for uncancelled appointments or those where we fail to give enough notice that we will not attend. We understand cancellations must be made at least 24 hours in advance. The only exceptions are unforeseen or unavoidable situations arising suddenly. We understand and accept that we are fully responsible for all fees, but that my therapist will help us in getting payments from any insurance coverage we have. We understand that this agreement will become part of our record of treatment.

My signature below means that I understand and agree with all of the points above.

_____ _____

Signature of client Date

_____ _____

Signature of client Date

I, the therapist, have discussed the issues above with the clients. My observations of this client's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.