Anthony Puryear, LCMFT
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CLIENT INFORMATION SHEET AND CONSENT FOR TREATMENT

Confidentiality: Psychotherapy is designed to be a safe place for you to talk about any personal issues you choose to explore. Please know that whatever we discuss in psychotherapy is legally held as private and confidential. This means that I will not divulge anything you tell me to anyone except in either of the following conditions:

a) You give me your permission to talk to another, such as a health-care professional who is providing you treatment.
b) You tell me something that I am legally required to reveal to others. For example, I am required to report cases of suspected child abuse or elder abuse, or when a client poses a threat to herself/himself or others.

If you are seeing me for couples therapy, I consider your relationship to be the client. During the course of our work, I may see one of you individually for one or more sessions or for part of a session. These sessions should be seen as part of the work that I am doing with the couple unless otherwise indicated. Please know that anything we discuss when your partner is not present may be disclosed to them if, in my best judgment, doing so is necessary to effectively help your relationship. Other than that, I will not disclose confidential information about your treatment to anyone else unless all persons who participate in the treatment provide permission to release such information.

In addition, a federal law known as The Patriot Act of 2001 requires therapists and others in certain circumstances to provide the FBI with client records and other items, and can prohibit the therapist from disclosing to the client that the FBI sought or obtained the items under the Act.

I also from time to time consult with other licensed, senior, experienced therapists on how I can better help my clients. These consultants are bound by the same laws of confidentiality outlined here.

The nature of psychotherapy: Therapy works best when you are an active partner in the process, so please know that I welcome your feedback or questions about our work at any time. Participating in therapy may result in benefits including but not limited to: improved interpersonal relationships; reduced stress and anxiety; better communication with loved ones; increased capacity for intimacy; a decrease in negative thoughts and self-sabotaging behaviors; increased comfort in social, work, and family settings; increased self-confidence and self-acceptance; greater ability to experience life more fully; more balance in life; and deeper self-awareness. Such benefits may require substantial effort on your part, including active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors as needed. There is no guarantee that therapy will yield any or all of the benefits listed above. Participating in therapy may involve discomfort, including discussing difficult feelings and experiences, and may evoke strong emotions, including anger, sadness, and fear. During the therapeutic process, many clients find that they may initially feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times while slow or frustrating at other times. You may also at times feel conflicted about attending sessions. If this is the case, I urge you to bring up your concerns so that we can address them. The process of therapy may sometimes result in unanticipated outcomes, such

as changes in personal or career relationships and goals. Please be aware that any decisions about your relationships, personal life, or work life are your responsibility.

Completion of Therapy: The length of your therapy depends on the specifics of your situation and the progress we achieve. As we approach the completion of your goals, I will discuss with you a plan for ending therapy. If during therapy you come to feel that the issues for which you are seeking therapy are not being satisfactorily addressed and you wish to see another therapist, I will offer you referrals to other therapists to assist in a smooth transition if you desire. If it becomes clear to me that you are not benefitting from our work together, I am ethically bound to stop treating you, and I will provide you with referrals to other sources for therapy. You may discontinue therapy at any time. Should you choose to end your therapy, I will generally recommend that we meet for at least one final visit to facilitate a positive termination experience and give us an opportunity to reflect on the work that has been done.

Fees and cancellation policy: My fee is $150 per session. Sessions are approximately 50 min. Payable each session by check, cash, debit or credit card. Longer sessions are pro-rated at the normal rate. There is no charge for brief phone calls (up to five minutes), but longer phone sessions with you or with any professionals or others you ask me to speak with on your behalf are subject to a charge based on the length of the call. When we schedule an appointment, that time is reserved entirely for you. Therefore, if you need to cancel an appointment, please let me know at least 24 hours in advance; otherwise, I will have to charge you for the missed session since I will not be able to fill the appointment time on short notice. If finances are an issue please discuss this with me so that we might be able to find a reasonable solution.

Court Testimony: The goal of psychotherapy is the reduction of stress and interpersonal conflict. Additionally, by starting treatment, you are agreeing not to involve me in legal proceeding or attempt to obtain treatment records for legal or court proceedings. In the event that I'm required to provide treatment records or testimony in any legal proceeding, you will be charged $150 per hour for any preparation time I spend getting ready to appear or turn over documents. You are agreeing to pay $600 per 4-hour block of time that I spend being "on call" to testify, traveling to and from court/deposition, waiting to appear, and/or testifying. The minimum charge will be for 4 hours of time and subsequent time will be billed in 4-hour blocks. The initial $600 is due in full one week prior to any scheduled court appearance/ depositions.

Therapist availability: You can leave messages for me anytime and I normally return phone calls within one business day. In a life-threatening emergency, call 911 immediately. E-mail and texting are not HIPAA compliant and therefore it is at your discretion to use these modes of contact. No advice or counseling will be done through text messages or e-mail.

Complaints: If you're unhappy with what's happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you can complain about my behavior to the Kansas Behavioral Science Regulatory Board at 785-296-3249. You are also free to discuss your complaints about me with anyone you wish, and do not have any responsibility to maintain confidentiality about what I do that you don't like, since you are the person who has the right to decide what you want kept confidential.

If you have any questions on the above, please ask me. Otherwise, please sign below. By signing, you acknowledge that you have reviewed and fully understand this agreement, that you have had any questions with regard to its terms and conditions answered to your satisfaction, and that you agree to the terms and conditions of this agreement and consent to participate in psychotherapy

CONSENT FOR TREATMENT

Sign Name:________________________________ Print Name:__________________________

Today's date:________________

Sign Name:________________________________ Print Name:__________________________

Today's date:_______________

Anthony Puryear, LMFT

Waiver of Medical/Psychiatric Consultation

I understand that under the provisions of KSA 65-64040 (b) (3) my therapist is required to consult with my primary care physician or psychiatrist to determine if there my be a medical condition or medication that may be causing or contributing to any signs of a mental disorder that he may have observed while working with me or my minor children. In the event that I or my minor children do not have a primary care physician and/or psychiatrist, I acknowledge that my therapist has recommended that I seek medical consultation.

I WAIVE MY RIGHT

By signing below I am indicating that I waive my right to such consultation and that I am aware that this waiver will become part of my record. This means that I am choosing I do not need or want my therapist to contact my primary care physician.

Client Signature:_________________________________ Date:_____________________

Client Signature:_________________________________ Date:_____________________

I DO NOT WAIVE MY RIGHT

By providing my physicians name and contact info, I am using my right for a medical consultation between my therapist and primary physician/psychiatrist.

Physician/Psychiatrist Name: ____

Office Address: ____

Phone: ____

Client Signature:

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