CONSENT AND NOTIFICATIONS

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(please print this out, hand-initial and sign then bring it to you first appointment)

QUALIFICATIONS

I received my Master of Social Work degree from the University of Nebraska in 1979 with specialties in medical and gerontological social work; I joined the Academy of Certified Social Workers in 1982; was awarded Diplomate in Clinical Social Work status in 1987 (a credential for distinguished advance practice of clinical social work issued the National Association of Social Workers); am licensed as an LSW in Pennsylvania (grandfathered for independent clinical practice); licensed as an LCSW in Arizona. Additional certifications and specialties include: Human/Companion Animal Bond; Death & Dying; Rankian/Functional Modality; Ethical Practice Education for Social Workers; Integration of Spirituality and Synchronous Guidance; Wright Protocol for Repair and Reattachment Grief Therapy; Emotional Transformation Therapy (ETT™), Rapid Resolution of Singe Event PTSD.

CONSENT TO TREATMENT

A. IF EVER IN A MENTAL HEALTH CRISIS CALL 911 OR GO TO THE NEAREST HOSPITAL EMERGENCY ROOM. I do not provide emergency treatment but do follow-up with clients when discharged from crisis care.

B. ONE-SESSION RESOLUTION OF SINGLE EVENT PTSD

1) The BENEFIT AND PURPOSE is to fully and permanently resolve PTSD symptoms stemming from recall of (and associations with) a single traumatic event.

2) The method(s) include evaluation, psychotherapeutic treatment by Emotional Transformation Therapy™ (and other protocols as needed) plus follow-up

3) While the success rate for total and permanent resolution of symptoms is 96%, no guarantee of success is made due to unpredictable variables among client perceptions, histories, brain functioning and ability to fully participate in therapy.

C. MULTIPLE-SESSION CARE

1) In general, the BENEFITS and PURPOSE of on-going treatment are the following, to be further specified in a Treatment Plan that you have the right to contribute to, approve, review and revise:

a) To know yourself better.
b) Alleviate emotional pain or confusion.
c) Assist you in developing a more complete understanding of your emotional issues.
d) Establish more effective coping mechanisms.
e) Foster a more accurate understanding of your past and what you want for my future.

2) There are THREE FUNDAMENTAL PROCESSES in psychotherapy that will help you reach these goals.

a) To develop trust or a “therapeutic alliance” with your therapist. During this period the treatment goals are defined and mutually agreed upon. The purpose at this point is to fashion a method of doing therapy that fits best with your personality.

b) In the second phase or “working through” process, the emphasis is on resolving confusions about past experience, and developing ideas about what you want and who you are. The desired outcome is to trust your intuitive process, feel unobstructed about the direction your life is taking, and to advance your efforts to enjoy a more healthy and productive life. The expected outcome from psychotherapy should be that you feel more “at home” in the world, more accepting of yourself and with your life choices.

c) The third or termination phase of therapy is to evaluate your progress, solidify what you have learned, resolve any remaining conflicts, and hopefully feel satisfied with your life and yourself. All three phases are essential to maintaining your psychological gains.

LIMITATIONS are defined by how interested and involved you are in your therapy. The more invested in the process you are, the more you will progress. Psychotherapy has **RISKS:** it can at times evoke anxiety, fear, anger, frustration, loneliness and dependency feelings. Unpleasant realities, however, can be faced and worked through. The emphasis is in replacing fantasy, myth, and untruths with authenticity. Your truth can at times, be painful, but will ultimately lead to more personal happiness and healthier relationships. The goal of psychotherapy is not to change you. Change is your choice. It is to build awareness, compassion, understanding, respect, empathy and acceptance toward yourself and others.

MODALITIES you might experience are Functional (Rankian), Support, Grief, Paradoxical, Cognitive Behavioral, Rogerian, Stress Management, and Emotional Transformation Therapy™. The latter, when used in conjunction with therapeutic dialogue might hasten the therapeutic process to the point where feelings of wellness can be achieved so quickly that you may find yourself dealing differently with family and friends who might not be ready for the changes you are making in your way of being with others. Thus, there exists a RISK of experiencing some discord as significant others need time to adjust to your new behaviors.

EMOTIONAL TRANSFORMATION THERAPY (ETT)™ is an innovative form of psychotherapy in which a highly trained therapist systematically uses specific wavelengths of light to interact with the client's emotional system. As with any form of psychotherapy, symptoms may temporarily escalate as unprocessed material is uncovered. Clients may experience increased distress, escalation of symptoms or new negative emotions prior to resolution. If symptoms become unmanageable, You are encouraged to call your therapist for assistance to address symptoms in a timely manner. ETT™ has been shown to be effective clinically, and research studies are currently being conducted to support ETT™ as an evidence-based therapy. The use of a light stimulation device is not recognized as medical treatment. All participation in therapy utilizing ETT™ light stimulation devices is strictly voluntary and experimental. Although some research findings are known, low light stimulation (40 watts) is currently viewed as a safe level of usage. There are no claims or guarantees of effectiveness made.

Are you having suicidal thoughts or are you deeply depressed?	σ yes σ no
Do you feel prone to violence or homicide?	σ yes σ no
Do you have a history of photosensitive seizures?	σ yes σ no
Do you have a life-threatening medical condition?	
Are you taking medications known to have photosensitive side effects? (If so, check with your physician to determine if these side effects are significant enough to avoid exposure to low brightness light stimulation)	σ yes σ no
Has your physician cautioned you regarding any excess exposure to bright blue light you previously experienced?	σ yes σ no

If you have any light-related concerns please explain:

I authorize and request that Linda Griffith, LCSW DCSW, utilize color resonance as well as traditional diagnostic procedures and/or treatments within a therapeutic relationship which now, or during the course of my care as a client, are advisable based on my participation in defining, reviewing and revising (as needed) the objectives for my care (Treatment Plan). I understand that the purpose of these procedures is to assist me in meeting my treatment goals and will be explained to me upon my request. While ETT™ specifically discourages emotional suffering through the reliving of trauma, I understand that the healing process sometimes involves provoking tolerable levels of discomfort before relief is achieved. I understand that at all times I have the right to refuse or withdraw consent to treatment following consideration of any consequences that I may experience as a result, of which Linda Griffith, LCSW, DCSW, will advise me. I further consent to achieving wellness quickly which carries with it the risk of redefining my life in ways that best serve me emotionally, mentally, physically and spiritually and might be unsettling to others. I understand that the greatest risk associated with ETT™ treatment is that the speed and ease with which I can become well might suddenly alter my view of myself and reality in significant ways.

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AGREEMENT REGARDING PAYMENT OF FEES

I understand that full payment of fees by cash, check or credit card is expected at the time services are rendered. I understand that I am responsible for all charges, and I agree to pay all charges. Unpaid fees may result in the reporting of my delinquent account to a collection agency and/or in a court judgement with additional fees imposed for collection and legal services.

(**MEDICARE: I** agree to pay for any for services not covered by my insurance. If a co-payment is required, it is expected to be paid at the time of each visit. If the co-payment is unknown, you will be billed for the amount at a later date.
AUTHORIZATION TO ASSIGN INSURANCE BENEFITS: ***I irrevocably assign to Linda Griffith, LCSW, DCSW all payments for medical/psychological services rendered and all major medical benefits payable.***

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INTENSIVE INTERVENTIONS:	
One-Session (up to 2.5 hours) single-event PTSD resolution	$ 500.00
Wright Grief/Reattachment Protocol (Up to 5 hours including follow-up session)	$ 500.00
ETT™ Samadhi Protocol (Up to 5 hours including follow-up session)	$ 500.00
MULTIPLE-SESSION THERAPY	
Evaluation (first session)	$ 135.00
Individual Therapy Sessions 60 minutes	$ 120.00

90 minutes (by necessity or request)	$ 180.00
120 minutes (by necessity or request)	$ 240.00
Telephone or Correspondence Consult Under 10 minutes	no charge
Beyond 10 minutes (cumulative per month)	$120.00 per hr.
Home/Institutional Visit Actual travel time plus 54 cents per mile	$120.00 per hr.
Records Review / Form Completion	$120.00 per hr.
Copy of Records Processing Fee (plus duplication costs and postage)	$120.00 per hr.
Missed Appointment** If less than 48 hours notice	$120.00
Insufficient Funds Check Fee	$ 50.00

**Many are often waiting for openings to become clients and, thus, a missed appointment not only is costly to me, but emotionally costly to whomever might have been able to get help in that time slot. Thank you for understanding this.

Credit card (required). Appointment fees outstanding 10 days beyond invoicing will be charged.
Name on card_____ Exp (month /year)_____
Card number_____ 3 digit code_____ Billing zip_____

I have read, understand and agree to the payment policies and fee schedule stated above.
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NOTICE AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The HIPPA form you are asked to sign below assures that written and spoken material from any and all sessions and psychological testing, is held strictly confidential and is protected, unless you give written permission to release all or part of it to a specified person or agency. Exceptions involve situations where the therapist is mandated to report suspicions of child or elder abuse and imminent danger to self or others, or your mental health record is used in your defense in litigation Exceptions:

1. The patient authorizes release of information with his/her signature
2. The patient presents a physical danger to self
3. The patient presents a physical danger to others
4. Child/elder abuse or neglect is suspected
5. Consultation is sought for your benefit with other professional associates (your name undisclosed)
6. Serious concern regarding your welfare warrants notification of your emergency contact
7. A complaint filed by you against the therapist necessitates release of information in the therapist's defense

I have received a copy of the Notice of Privacy Practices (available for download at www.counselingtucson.com or in print by request)
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HIPAA PRIVACY AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. **Authorization** I authorize Linda Griffith, LCSW, DCSW (healthcare provider) to use and disclose the protected health information described below, as applicable, to:
   - to my insurance carrier(s) and/or managed care company concerning this illness and treatment
   - to personnel hired or contracted by Linda Griffith, LCSW, DCSW to assist in the evaluation of benefits, billing, processing of insurance claims or other administrative tasks
   - ETT™ (Emotional Transformation Therapy) Master Teachers and Consultants for purposes of professional consultation regarding advanced and developing techniques that may benefit my treatment
   - other qualified medical and psychotherapeutic professionals with whom consultation is deemed by Linda Griffith, LCSW, DCSW to be beneficial or necessary
2. **Effective Period** This authorization for release of information covers the period of healthcare from all past, present, and future periods during which I remain in the care of Linda Griffith, LCSW, DCSW and/or have outstanding invoices or insurance claims pending.
3. **Extent of Authorization** I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until I revoke it in writing, at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is

not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization except the extent that a refusal to release information to insurance companies and personnel responsible for processing claims may result in unpaid claims for which I am then financially responsible.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

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PROTOCOL FOR SECURE STORAGE, TRANSFER AND EXTENDED ACCESS TO MEDICAL RECORDS

Client records shall be stored in a doubly locked location on the premises of the practice for a period of seven years. In the event that the practice of Linda Griffith, LCSW, DCSW is terminated or sold, the electronic mail address of the practice shall remain active for seven years following closure of the practice through which clients may continue to request copies of records without interruption. At the end of the seven year archiving period, a patient's records shall be destroyed by secure shredding. Electronic records received in the course of providing intake information shall be permanently removed from electronic storage upon the client's creation and provision of paper copies of the information and completion of the client's evaluation and Treatment Plan. You may obtain a copy of your record by requesting it in writing and paying the therapist's customary. per hour fee for processing plus any per page duplication and postage fees applicable to delivery. Records requests will be met by a sincere effort to process them within 5 business days, excluding periods of travel or vacation.

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ELECTRONIC COMMUNICATION ACKNOWLEDGEMENT AND AGREEMENT

I understand the risks associated with the communication of e-mail and texting as set forth in this consent form. Despite the confidentiality risks associated with e-mail and texting, I agree that Linda Griffith, LCSW, DCSW, may use e-mail and texting to facilitate communications with and about me. I understand that electronic disclosures regarding my treatment and diagnosis may be made to not only me but also internally within the Practice's office or to appropriate third parties for services such as billing and/or treatment. Linda Griffith, LCSW, DCSW may call my phone number(s) and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, such as appointment reminders, insurance items and any calls pertaining to my clinical care. Linda Griffith, LCSW, DCSW may mail to my home or other alternative location any items that assist the practice in carrying out treatment, such as appointment reminder cards and patient statements.

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In placing my signature below, I attest that I have read and understand all of the information contained on this form and agree (as evidenced by my initials) to the terms defined in each subsection.

_____ _____

Signature of Client (or Client's Legal Representative) Date

_____

Printed Name of Client

_____

Printed Name of Client's Legal Representative