

# LightSource Counseling, Inc.

Lisa Ferguson  
 LCAC CSAT CADAC II CCPS  
 EMDR (EMDR/IA) Certified Therapist

Licensed Clinical Addictions Counselor  
 Certified Sex Addiction Therapist  
 Certified Clinical Partner Specialist  
 8000 West River Road.  
 Yorktown, IN 47396

## AGREEMENT BETWEEN CLIENT AND THERAPIST

The following is an agreement entered into between **LightSource Counseling, Inc.**, Lisa Ferguson, LCAC, CSAT, CADAC II, CCPS, EMDR certified therapist and \_\_\_\_\_ as client(s).

### PROFESSIONAL DISCLOSURE STATEMENT

**Qualifications:** I am a practitioner within the field of trauma, chemical and process addictions, and sex and love addictions. I have been trained by Drs. Patrick and Stefanie Carnes, and certified (CSAT) through the International Institute of Trauma and Addiction Professionals. I am licensed in the State of Indiana as a Clinical Addictions Counselor. In addition, I am a Certified Clinical Partner Specialist (CCPS), trained to work with the specific needs of partners of people with sexual addictions, and am an EMDR (EMDR/IA) certified therapist. The distinguished clinicians on my LightSource Board of Directors, as well as my internationally certified supervisor/consultant colleagues, consult and staff with me on a regular basis, providing me the highest quality of input for my clients. I believe this is the best way to fulfill my goal of providing you with the highest level of care possible in an outpatient practice.

### INFORMED CONSENT

**Therapeutic Relationship:** During the time that we work together, we will meet at a mutually agreed upon frequency. Our contact will be limited to psychotherapy sessions that you arrange through **LightSource Counseling, Inc.**

**Psychotherapy is a Difficult Process:** It has been said that during the process of psychotherapy, clients often seem to get worse before they can get better. I will take this journey with you, supporting you as you move forward; however, **you are the one who must do the work of recovery.** Your willingness to work hard, receive and work on therapeutic recommendations, and make a commitment to the recovery process are the ingredients that are necessary for you to achieve and maintain long-term sobriety or healing from trauma as the case may be, and to attain eventual balance in your life.

**Communication:** LightSource Counseling, Inc. utilizes a variety of means to communicate with clients regarding scheduling and other coordinative aspects. The dominant form of scheduling coordination and reminders is by mobile texts and sometimes email. Please note that phone or digital contact is not always secure, however LightSource will take every reasonable precaution to protect your privacy. LightSource standard policies dictate hours of contact will be between 7 am and 9 pm except in unusual circumstances. However, **we ask you to reserve therapeutic questions for your appointments**, as we will not be addressing them via e mail or text for ethical and confidentiality reasons. Our preference is to limit text and email communication with clients. **All therapeutic discussions must happen in office or via phone sessions per the best judgement of the therapist.** Sensitive information sent to the therapist will be purged immediately after receipt. LightSource purges all other communication every six months.

**Benefits and Risks of Treatment:** The benefits of outpatient psychotherapy may include improved functioning in your personal and professional relationships, improved communication skills and a reduction in the symptoms that led you to seek therapy in the first place. Psychotherapy also has risks. Dealing with addictions will often bring up a number of unpleasant memories and feelings during our sessions. The same is true for recovery from partner trauma. These feelings are natural and are important to the recovery process. Therapy may also cause an escalation of undesired behaviors, relationship disruption, and emotional reactivity. In the pursuit of healing and recovery, this is a necessary phenomenon, and moves you towards an ever-increasing understanding and regulation of your daily life. Your signature below indicates that you are aware of the fact that psychotherapy involves risks as well as benefits and agree to move forward with psychotherapy in LightSource Counseling, Inc.

**If I am seeing Both People in a Coupleship:** I will do individual intakes, make individualized treatment plans, and have each person sign a NO SECRETS agreement that gives detailed orientation as to the parameters and nature of what may and may not be shared by the therapist with the other person in the coupleship. Although I may work with you periodically in sessions where both parties are present (a couple's session to discuss progress and/or possible changes in therapeutic recommendations, or when you are moving

through the stages of Therapeutic Disclosure) **you are still classified as individual clients.** I do not do couples' work in sessions until I have seen each individual for a period of time. *This may be as long as a year or more*, depending on the needs and presenting issues of the individuals involved. **PLEASE NOTE: it is imperative for each person to progress towards his or her own mental and emotional health**, even if reuniting the coupleship is your stated goal. If this is not acceptable to you, LightSource may not be the best choice for your therapy.

**Emotional Triggers:** A trigger is when something *feels* like something disturbing that happened to you at an earlier time in your life. For example, when a coworker gets a promotion, one may feel angry, perhaps due to a deep shame trigger from an event even in childhood where someone else was chosen for something one wanted to be chosen for.

In recovering couples, it is common for each individual to be 'triggered' by something their spouse says or does/fails to do. Making decisions (such as filing for divorce, telling the children about discovery of betrayal, or changing the direction of your therapy) during a 'trigger', argument, or in the heat of anger, is **highly contra-indicated.** By your signature below, you agree to consider the above statement as you go forward with your therapy in LightSource Counseling, Inc.

**Transference:** Transference is when a client experiences emotional triggers in therapy that remind them of dysfunctional relationships of their past. Clients will sometimes transfer these negative feelings to the therapeutic relationship, or to the therapist in particular. An example of this would be that someone who had a controlling mother or father may interpret therapeutic recommendation as a therapist 'trying to control' them. Should this, or any other disturbance occur to you in a therapeutic session or between sessions, I ask that you **bring it to my attention in a respectful way during session, or during the next session.** It is never my intention to offend in any way. Accordingly, if I recognize this is happening, I will address it with you respectfully. By signing below you agree that you will be open with me, and open-minded about my observations as well as respectful when discussing it with me. Your signature also indicates that you agree that any discussions you may have with others about these matters be likewise respectful to this practice. This is for the good of all involved.

**Therapeutic Recommendation:** Recoveries from Addictions and Partner Trauma are very serious matters, and are often time-sensitive. Therefore, if you are seeing me for Addiction Recovery or Partner Trauma recovery, I will be making available to you powerful psychoeducational materials, coaching, self-monitoring techniques, and sometimes EMDR processes that will help you quickly become stabilized and grounded in your recovery. In this regard, **your willingness to embrace Therapeutic Recommendations will directly influence the speed of your recovery.** For this reason, LightSource Counseling, Inc. may be very different than other counseling you may have received or heard about. For example, although I am a great proponent of client self-determination, I nevertheless advise my clients not to make any major life decisions within the first year of recovery, unless safety is an issue. Accordingly, it is the philosophy of this practice that decisions that involve coupleship, sexuality, family of origin, job or shift changes, travel, as well as how and what to reveal to children, friends, family members and others, etc., **be arrived at with therapeutic consultation.** Input from the therapist on these matters is **often essential and can save you much time, money, and heartache.** By signing below you agree to consider this as you go forward in your therapeutic process with LightSource Counseling, Inc.

### **Client Rights and Responsibilities**

You have the right to refuse or discuss modification of any of my psychotherapy techniques or suggestions that you believe might be harmful. Secondly, some clients need fewer psychotherapy sessions than others to achieve their goals. For addictions recovery, however, it is typical to expect three to five years to complete therapeutic process. For partner trauma and/or relationship navigation, a period of years is also likely and usually recommended. With this in mind, know that you may nevertheless end our therapy relationship at any time. In such cases **I ask that you participate in a closure session** in my office in order for me to enumerate points of progress you have made, weaknesses you have still to address, and reasons for the termination of therapeutic relationship. By signing below, you are agreeing to schedule a closure session when you leave this practice. You are also agreeing that, upon leaving therapy with LightSource Counseling, Inc., you will not verbally or in any other way undermine my therapeutic relationship with any of your peers or group members who may be benefitting from ongoing therapy in LightSource.

Lastly, you hereby further agree to come to all therapy sessions free from the influences of drugs including alcohol.

**Referrals:** Should you and/or I believe that a referral is needed, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to psychotherapy will also be made available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives.

**Individual Therapy Session Length and Fees:** Individual sessions are typically 1–2 clinical hours (clinical hour = 50 minutes), and the fee is \$140.00/clinical hour. Programs are available that aggregate a number of sessions in advance (by the 5<sup>th</sup> of the month) at a reduced hourly rate. Intakes are a flat rate of \$300. Off hour fee (after 6 pm) is \$160/clinical hour. Consultation during out of office hours (Friday through Monday) is at a rate of \$180/clinical hour. For New Life Presbyterian Church members a discounted rate is

available. Family intensives are \$160/hr. Sessions that extend beyond the clinical hour will be billed for the additional time to the nearest half hour. (for example, a session that extends to 60 minutes will be billed at 1.5 hours). All session rates are posted on the LightSource Counseling, Inc. website under Services.

**Additional Therapists/Associates: LightSource Counseling, Inc.** will, from time to time, have additional therapists/associates involved in some aspects of the treatment and billing of clients. Involvement of other therapists, Board members, and associates may occur as part of ongoing therapist education, training, supervision, and peer mentorship, as well as group therapies, special events, or Therapeutic Disclosures and Intensives. These therapists and associates are bound by the same confidentiality as Ms. Ferguson and may also have access to certain client records.

**No Emergency Calls:** This office does not take emergency calls. If you have an emergency, you must go to your nearest hospital emergency room or call 911.

**Cancellation and Missed Appointment Policy:** Cancellations of individual, couples, and family psychotherapy, and psychotherapy by telephone, requires **48 hour advance notice** to avoid being charged for the missed appointment. (Advanced cancellation of Monday morning appointments should be made to the therapist's on-call phone ((765) 276-0407). Dire emergencies (i.e., hospitalization, accident, death in the family) are addressed on an individual basis. Late cancellation and missed appointments are charged to the client's credit card on file.

**Insurance Waiver and Agreement:** This office does not file insurance claims. However, a receipt for reimbursement will be provided upon request. Most insurance plans require a diagnosis as part of filing a claim. This diagnosis will be discussed with the client(s) prior to providing a statement. The client(s) understand that verification of benefits or pre-certification of services does not guarantee that an insurance carrier will reimburse this type of outpatient intensive service, and the client agrees to pay for these services in advance.

**Miscellaneous Fees:** In the event of premature departure from therapy, there is a \$250 fee for compiling and transferring records to other professionals. In event of legal cases, where extensive records may be required, an \$800 fee will apply for record requests.

**Court appearance and/or testimony are NOT provided by LightSource Counseling, Inc.** There is a \$160 flat-rate charge for each letter clients request being sent on their behalf. Travel time for such services as formal disclosure or family therapy is billed at the therapist's hourly rate plus mileage.

**Records and Confidentiality:** All of our communication becomes part of the clinical record. Records are the property of **LightSource Counseling**. Most of our communication is confidential, but the following limitations and exceptions do exist: a) I determine that you are a danger to yourself or someone else; b) you disclose abuse, neglect, or exploitation of a child, elderly, or disabled person; c) you disclose sexual contact with another mental health services provider; d) I am ordered by the court to disclose information; e) you direct me to release your records; or f) I am otherwise required by law to disclose information. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first. Office clerical personnel will only have enough information about you to schedule appointments, contact you, and facilitate collection of fees.

In the case of couples or family psychotherapy, I will keep confidential (within the limits cited above) anything you disclose to me without your family member's knowledge, except for in the case of couple's therapy in which you sign a "No Secrets" agreement. I encourage open communication between family members and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to therapeutic progress.

**Weapons:** Clients agree not to bring any weapons into **LightSource Counseling** offices. This includes all law enforcement officers.

**Physical Contact:** Sexual Contact is never acceptable in the therapeutic relationship. Romantic or sexual talk, sexual innuendos and sexual jokes are also unacceptable in the therapeutic relationship. If you should express a sexual comment or joke while in session directed at me, we will explore this comment professionally and in a non-shaming way within a therapeutic non-sexual relationship. Hugging is an expression of affection, a greeting, or a goodbye within many cultures. However, in some cases hugging may be misconstrued as sexual, and can be triggering for some clients, or may interfere with the therapeutic relationship. Occasionally a client may ask for a hug after a particularly difficult or emotional session. It is important for me to understand your stance and to maintain appropriate professional boundaries. If I believe after we discuss the request that a non-sexual brief hug is appropriate and supports your therapy, I will allow this on occasion. Please understand, if I choose not to hug you it is not an expression of judgment, dislike or dismissal, rather it would be denied in the best interest of your clinical care based on a therapeutic decision.

**Unpaid Debts/Returned Checks:** Payment is required when services are rendered. Unpaid debts will be turned over to a collection agency. Collection fees will be added to the client(s) bill. Returned check (i.e., insufficient funds, etc.) charge is \$30.

**Acknowledgment and Consent:** By your signature(s) below, you are indicating that you have read and understand this statement, that you have had an opportunity to ask questions, that any questions you have about this statement have been answered to your satisfaction, and that you were furnished a copy of this statement.

By my/our signature(s), I/we agree to the terms and conditions outlined within this document. (Each participant is required to sign this agreement form.)

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Client Signature \_\_\_\_\_ Please Print Name \_\_\_\_\_ Date \_\_\_\_\_ Telephone Contact Number \_\_\_\_\_

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Client Signature \_\_\_\_\_ Please Print Name \_\_\_\_\_ Date \_\_\_\_\_ Telephone Contact Number \_\_\_\_\_

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Therapist's Signature \_\_\_\_\_ Date \_\_\_\_\_

**We require that you have a credit card on file with our office to guarantee appointments. No shows and late cancellations (see above) will automatically be billed to your credit card. At the time of your session, you may pay by cash, check, or credit card. This information will be encrypted.**

Type of card:  Visa  Master Card  American Express  Discover

Account Number \_\_\_\_\_ Expires \_\_\_\_\_ CVV# (back of card) \_\_\_\_\_  
Month Year

Name on Card \_\_\_\_\_ Signature \_\_\_\_\_

Billing Address \_\_\_\_\_ Zip Code \_\_\_\_\_