

LightSource Counseling, Inc.

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

Consent for Treatment in Group Therapy

We want to welcome you to group therapy at LightSource Counseling Services. It is important that you first review the following information and policies. In order to start the next module, you will need to sign and date these forms and bring them with you to the first group meeting or submit them in advance. **You may not begin group without these forms in place.** Please feel free to ask any questions you may have.

- **Your confidentiality is very important to us.** Your therapist will not acknowledge you as a client, or share any information with anyone about you without your prior written consent. Should you request that your therapist speak with another professional or person (i.e. doctors, current or former therapists, spouses, teachers, family, friends or anyone else outside of the therapy room), your therapist will first ask for your written consent. This form is called a Release of Information and can be found on the LSC website, under the 'Resources/Forms' section at www.lightsourcecounseling.com. It will be at your therapist's discretion to agree to discuss, consult, or meet with your requested party even with this written release in place as it may not support your healing process to do so.

- Please keep your group therapist's contact phone number on hand. Messages are checked daily by each therapist, and calls will be returned as soon as possible. **Please always leave your phone number**, even if you think it is on file, and the best time to reach you. Let your therapist know if it is urgent and cannot wait until group, and if your therapist may leave a message at your phone number. If it is a life and death emergency, you are advised to call 911 immediately and not to wait for a return call from your therapist. Please respect your therapist's boundaries around frequent contact outside of group.

- **In order to attend a group with LightSource, you must have a minimum of 3 months of therapy within the last year or have special permission/invitation from your LightSource therapist, and must be currently attending therapy.**

• **What you disclose in group therapy is confidential. However, there are limits to confidentiality.** LightSource Counseling takes confidentiality very seriously. Your information is confidential, with the exception of information relating to child abuse, or suspected child abuse, child pornography, elder abuse, dependent adult abuse, or intent to harm self or others, or **unless mandated by a court of law**. Legally, therapists are mandated reporters of abuse or intent to harm another. If you are suicidal or homicidal, your therapist Services will take all reasonable steps to prevent harm to you or another.

Legal exceptions to confidentiality are in place to protect your safety and the safety of others. This includes: when there is a reasonable **suspicion** of child abuse (physical, sexual, emotional, neglect), or adult dependent care abuse, elder abuse/neglect; and where a client threatens to harm or kill other(s) (homicide), or threatens to damage another person's property.

If you are homicidal and make a serious threat to hurt another person(s), your therapist will contact 911 and make every attempt to warn the intended victim or victims. Additionally, if court ordered to release records your therapist must abide by the court order.

Mandated Reporting of Incidents Involving Minors

A minor is defined as any person who is legally under the age of 18.

Your therapist is obliged under Indiana law to report to the appropriate authorities any instance where a client discloses that they have accessed, streamed, or downloaded material through any electronic or digital media depictions where a child is engaged in an obscene sexual act.

Should you choose to disclose that you have accessed child pornography of any kind (currently, recently, or in the past) during any of the following:

- a session with your therapist
- via your client consent forms
- an assessment tool that is administered as part of your treatment, such as the SDI (Sexual Dependency Inventory), or via other assessment tools (such as the SAST or Sex Addiction Assessment Tool) that are administered by LightSource Counseling
- during an individual, group, or couples session in the office
- via email, text, phone, regular mail
- or by any other means in or out of session

it is important for you to understand that **your therapist is mandated to report this to legal authorities.**

Please know that anything disclosed by you around offending behaviors by yourself or other family members with minors (a person under the age of 18 years old) is an offense that your therapist is mandated to report.

Please sign and date here if you understand the above stated limits of confidentiality and mandated reporting responsibilities of LightSource Counseling Inc.

Client's signature: _____ **Date:** _____

• **Confidentiality when working with others you know:** There are occasions where your LightSource therapist may provide therapy for someone you know (a spouse, family member, co-worker or friend. If your significant other is seen in some capacity within the LightSource practice, boundaries of confidentiality will be upheld on both sides unless there is a Release of Information in place. Thus, what you share in group stays in group. If you ask for information regarding a person you know that is also a client of LightSource, this will not be discussed with any client unless there is a signed release of information in place from that person.

• **Acknowledgment of Attendance:** Please sign here if LightSource Counseling Inc may acknowledge your attendance in group to your spouse, friend, family member or significant other. Please note that acknowledging you does not give permission to share details or information from your group therapy:

Name of person you may acknowledge my attendance to is:

Relationship to this person is:

Client's Signature of Consent:

Group Rules:

- You agree to be free of drugs or alcohol during group therapy sessions.
- You agree to make arrangements for child care as this is an adult setting.
- Recording (visually or audibly) in group is not permitted.
- You **will not** be reimbursed for missed groups if you are utilizing any of the

discounted rate options (paying for each month by the 5th or paying for the whole 12 session module before the end of the first meeting.) This is due to the fact that your place in group is reserved for you.

If you are unable to abide by the group rules, are not able to respect boundaries, or the therapist's direction and feedback, the therapist will speak with you to review the group rules and policies. If after discussing this with you, you continue to disrupt the group with absences or other disrespectful behaviors, you will be asked to leave the group. A therapist is under no obligation to keep a client in group if they do not feel it is in the best interest of the client or the group process.

- **Cell Phones:** Some clients use their smart phones for particular group exercises (i.e. to play a song, or read part of the homework, or follow along in the book). This is fine, as well as the use of the cell phone to text privately with the therapist during remote sessions or if connection is lost. However, as a rule, due to the sensitive nature of group therapy, unless you are using the phone in some way to participate in or enhance the therapy group work, we ask that you turn all electronic devices, cell phones and pagers completely off (this includes ringers, camera or video phones, music tones, and the vibrate, 'buzz' or silent mode, or flashing light mode), in order to respect the process and other group members during the sessions. However, if you need to have special access to these devices during a particular session, please just make this known to the therapist before the start of the session.

- **Group therapy sessions are twice per month unless otherwise specified and are scheduled in advance.** Each group therapy session is 90 clinical minutes (75 actual). The group is closed at 8 members, with 2 spots held for new clients in need. You have a reserved spot in this group for 12 sessions. This means that you are agreeing to honor your commitment to the group process. We ask that you try not to miss more than 2 meetings in a module as this impacts the flow and bonding of the group.

- **Payment:** Payment is due before the first meeting of each month for all group meetings in that month. For the discounted rate, payment is due by the 5th at midnight. All payments are non-refundable whether or not you attend group.

- **Contact:** Please respect the privacy of your group members in contacting one another via phone or email. Some group members prefer to maintain their privacy outside of group, while others welcome the contact. The best rule is to ask the group member what they prefer. If you should run into each other in public, please understand that not every group member may welcome contact outside of group depending on their individual circumstances. Please respect confidentiality boundaries.

Please respect boundaries around frequent contacting of the therapist outside of group.

- **Meeting outside of group:** It is up to you if you choose to meet with one another outside of group. While you may bond with some members over others, please consider

reducing cliques and exclusivity as part of your group experience. Please keep high standards by refraining from gossip or negative comments about your fellow group mates or your therapist.

- **Professional Conduct:** Each member is welcome to discuss their work in group as it applies to their healing process. However, networking for business or soliciting other group members for business ventures, sales, etc. is not a part of therapy. Please refrain from doing this within group.

- **Group Homework:** On occasion exercises will be assigned in group. Homework is sent via email and you are responsible for printing and keeping track of your homework. The group therapist is not responsible for printing services. Some of the exercises may stir up feelings that are difficult for you. You are asked to participate to your comfort level and keep the group therapist apprised of any difficult or challenging feelings that arise.

If you are triggered by a particular reading assignment or exercise, please set the homework aside until you speak to the therapist and/or your coach. Each person will have his or her own experience with group assignments. Some members may enjoy a particular exercise, book, article and such, while others may not.

Your honest experience with exercises, assignments, and reading is important and valuable, however, please refrain from making ongoing derogatory statements about the homework or exercises while reflecting in group as this may bring up shame for others, and may impact their willingness to share openly if they had a more positive experience with the homework. A group book will be assigned each module. This is your responsibility to purchase and to stay on top of the reading.

- **Profanity or Slurs:** Please express yourself appropriately and with limited profanity as profanity may be triggering to certain group members who have early trauma with respect to a parent's or significant others use of profanity. It is understandable that some profanity may occur and the therapist makes room for this, however, regular ongoing use of profanity will not be accepted, as with language that is vulgar, triggering, hurtful or demeaning to others (i.e. ethnic insults, sexual orientation slurs, gender or racial slurs, or offensive spiritual remarks)

- **Spirituality:** It is important to note that not everyone in group will share your spirituality or religious beliefs and practices. Clients attending group may be of many different faiths, or may not have a formal religion at all. Please do not assume your higher power is the same for each member. Additionally, some individuals have spiritual and religious trauma. While you are welcome to discuss your faith, your God, and/or your spiritual path, please do so with sensitivity and respect the boundaries of others.

- **Non Discrimination:** LightSource does not discriminate on the basis of race, sexual orientation, religion, gender, or for any other reason. We welcome into our groups many different individuals from many different backgrounds. We do not tolerate racial,

religious or sexual orientation slurs or insults. Doing so is a form of bullying and is not tolerated. We seek to create safety and connection in group and ask that you refrain from this kind of behavior.

- **Group Focus:** Please respect the boundaries of other group members and the facilitating therapist. Group therapy is about growth, insight building, challenging self, and healing. Feedback from group members should be given only with permission either from the therapist or the individual, and is to be framed with truth, respect and affirmations.

Refrain from behavior that will impede the flow of group such as: complaining at length, sarcastic remarks, tardiness, multiple absences, going on at length, frequent interruptions, challenging other members or the leader in an aggressive manner, silence, passive aggressive comments, refusing to receive or give feedback, negative criticisms, and/or monopolizing time during your share.

- **Group Process:** We typically start each group with highs and lows of the week. This means that you will be asked to share ONE high and ONE low from your week and to be open to feedback from the group. This is not the time to discuss at length all of your highs and lows of the weeks, please choose one of each to bring into group so that each person has a chance to share and to receive feedback and so that the group has time for the exercise processing. If you tend to run over, the group therapist will ask you to wrap up your share time.

- **Group Feedback:** The group therapist will give you clinical feedback both within group and periodically outside of group in order to help support your process. This feedback is an important part of the group experience. When you are receiving feedback, please do not interrupt the therapist or another group member unless you are feeling highly triggered by this feedback.

- **Terminating Group:** Because of the bonding aspect of group, if you are unable to finish a module due to an unforeseeable crisis or emergency, we will ask that you attend a final group in order for the other members to have closure. Your fee will stand for the remainder of the group meetings, unless the reason for your early departure is due to a life-threatening emergency or health crisis.

Please note that the group experience is different for each member. Some members may attend 1-2 modules and receive the support and growth they need, while others may find that they will attend group much longer than this, some for years. **Moving forward into the next module is at the discretion and direction of the group therapist.** If you are not asked to move forward, it is not a negative statement about you as an individual.

There are many reasons why a group therapist may refer a client out of the group including: The client has received what he or she needs from the group, the client is breaking group rules, the client is no longer participating in group in a way that supports

the client's growth or the group, the client is missing groups, the client has met their group goals, the group no longer serves the needs of the client.

If you are referred out of group and/or you are not asked to move forward into the next module, please understand that this is a clinical decision and in the best interest of your healing process and that of the group. We will do our very best to provide you with other support referrals that may include 12-step or individual therapy. By the same token, if you choose not to move forward to the next module, the group therapist does not personalize this decision.

Client Contact Phone#: _____

Emergency Contact Person: _____ **Phone #:** _____

Relationship to you: _____

Are there any physical or mental health issues that your group leader needs to be aware of? If so, list here:

If there is a health emergency within group and your group therapist is required to call 911 on your behalf you give LightSource Counseling Inc. permission to do so and agree to assume all financial debts related to this. **Please initial here** _____.

Is there anything else that will be important for your therapist to know? If so, list here:

PLEASE REVIEW, SIGN AND DATE THE FOLLOWING PAGE AND BRING THESE FORMS TO YOUR FIRST GROUP MEETING, or SUBMIT THEM VIA EMAIL PRIOR TO YOUR VIRTUAL GROUP MEETING. YOU MAY NOT ATTEND GROUP WITHOUT THE SIGNED AND DATED FORMS. THESE FORMS WILL COVER ALL GROUPS AND MODULES FROM THE SIGNED DATE FORWARD UNTIL TERMINATION AT A FUTURE DATE/MODULE.

I, _____ consent to treatment in Group Therapy with LightSource Counseling, Inc.

- I recognize that any information I hear within the group revealed to me by other clients is strictly confidential. I agree not to disclose the name of or any information related to any member of the group to anyone outside the group. Such a violation of this trust will likely result in immediate termination from the group.
- I agree to follow the rules of group as outlined on the intake form. I understand the limits of confidentiality as outlined in the Group Policy Form. I understand that a therapist is a mandated reporter of abuse.
- I understand that my spot is held for me for these 12 sessions and that the fee is due for each session even if I do not attend. I understand that fees are due for the month at the start of that month, and that monthly fees are discounted if paid in full by the 5th of the month at midnight.
- I understand that if I am unable to respect the boundaries of the group, I will be asked to leave. I understand and agree to respect the therapist's clinical direction. I further understand that even if I abide by all the policies and group rules, I may be referred out of group after the module ends to another group or another form of therapy outside of LightSource Counseling as determined by the therapist. I understand that this is not a personal statement about me; rather it is a clinical direction by the therapist in what best supports my clinical needs.
- If my group therapist sees a spouse, partner, friend or family member in another group or for individual therapy, I understand that the therapist will not discuss my group therapy information or experience with my spouse, friend or significant other, nor will my group therapist answer questions or discuss with me any information that my spouse, friend or significant other may share in their therapy or group unless the necessary Releases of Information are in place.
- I understand that my therapist will not be placed in the position of a secret keeper. If my group therapist works with my partner or spouse in some other capacity at LightSource, and I reveal a secret in group that could impact my significant other, I agree to work with my therapist to reveal this information in a clinical session.

If you have any questions please discuss this with your therapist. Your signature indicates you understand and agree to group policies, limits of confidentiality, group rules, fees, attendance, termination, and referral out of group.

I have read, understand, and agree to the above clinical policies:

Client's signature: _____ Date: _____

Client's name (printed): _____

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Client Credit Card Authorization Form

Please note that the information on this form will be securely entered and stored in a HIPAA compliant online virtual terminal that is password protected for your safety. Once your information has been entered by your therapist to the secured terminal, these paper forms will be destroyed immediately to protect your information. While all secure methods to protect your information are in place, and we take your safety seriously, no company can 100% guarantee that any online system cannot be breached, thus you are accepting responsibility and risk in allowing LightSource Counseling Inc. to store your information for therapy charges.

I authorize my therapist with LightSource Counseling, Inc. to keep my signature and card information on a virtual terminal file that is password protected and HIPAA compliant in order to charge therapy session fees (individual, group, workshops, couples, family or other), and any fees related to therapy related materials (workbooks, DVD's, CD's, and other materials, and/or fees), or for any appointments with my therapist that are not cancelled 48 hours before the scheduled appointment time to be charged to my credit, charge, or debit card as filled out below for therapy services provided to:

(Therapy Client's Name: Please Print)

I understand that this authorization is valid until canceled in writing. I understand that though this information is secured in an online protected client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I agree that the card listed below may be charged by my therapist with LightSource Counseling, Inc. in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials (i.e. books, CD's, DVD's) that I have not returned within one week of completion of my therapy services. I understand that if a charge back fee is incurred or a retrieval fee of is incurred I am responsible for these fees. _____ (Initial here)

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact my therapist with LightSource Counseling for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with my therapist and those attempts have failed. _____ (Initial here)

Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by LightSource Counseling, Inc. _____ (Initial here)

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Name (print): _____

Signature _____

Relationship to client: _____

Billing Address: _____

Zip Code: _____

Card Type (**circle one**): 1. Visa 2. Mastercard (Note: GCS does not accept AMEX)

Acct. Number: _____ - _____ - _____

Exp. Date: _____

I understand that my therapy sessions will be charged unless cancelled 48 hours in advance:

Cardholder Signature: _____ Date: _____

Acknowledgement of Receipt of Privacy Practice Notice

By signing below, I hereby acknowledge receiving and reviewing the LightSource Counseling Inc. Notice of Privacy Practices and Limits of Confidentiality.

Client's Name (print)

Signature of Client

Date