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## Informed Consent for Group Counseling

**Group Process.** Group counseling can be a powerful and valuable environment for healing and growth. It is the desire of your group therapists that you reap all the benefits group has to offer. To help this occur, groups are structured to include the following elements: A safe environment in which you are able to feel respected and valued as you work, an understanding of group goals and group norms and an investment by both your therapist and members to produce a consistent group experience.

This counseling practice provides training to students interested in acquiring licensure in counseling. Interns have already undergone extensive schooling and worked within the counseling arena yet are working towards, but do not yet have, full licensure in the state of Arizona. Some groups are facilitated by interns or associate level therapists. As such, I am considered a patient of Arrowhead Family Systems, and may be seen by an intern/associate, who receives supervision by Dr. Kimberly Bailey, DBH, LMFT. On occasion, as part of the training protocol, you consent to allow video or audio recording the session, and/or have a supervisor sit in on the group. You have the right to refuse these options, yet we do so for the sole purpose of furthering the counselor's skills and work with you or your child.

**A Safe Environment.** A safe environment is created and maintained by both the therapist of the group and its members. Mutual respect and a chance to create trust are primary goals of the group process. Providing a safe environment is based on confidentiality. Your group therapist is bound by law to maintain confidentiality, as group members are bound by honor to keep what is said in the group in the group. We realize that you may want to share what you are learning in group, with a family member. This is fine as long as you remember not to talk about how events unfold in the group or in any other way compromise the confidentiality of other group members. Parents of adolescents participating in group need to remember that their teen is in group to learn about topics that are meaningful and at times confusing to them. Being able to express themselves freely in the group, is part of the process of learning to become more honest with one's self and choices one wants to make. Knowing that you trust the group process may be helpful in their group experience.

If there is ever a time when you believe that you have been treated unfairly or disrespectfully, please talk with the therapist or Dr. Kimberly Bailey, DBH, LMFT at 623-570-3634. It is never any intention to cause this to happen, but sometimes misunderstandings result in hurt feelings. We want to address any issues that may get in the way of therapy as soon as possible.

**Confidentiality.** Ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. We do not allow any audio or video recordings to be initiated by any group members. You should know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required to inform you of my actions in this regard. These situations are as follows: (a) if you threaten grave or bodily harm or death to another person, I am required by law to notify the appropriate parties or authorities; (b) if a court of law issues a legitimate court order (signed by a judge), I am required by law to provide the information specifically described in that order; (c) If you reveal information relative to child abuse, child neglect, or elder abuse, I am required by law to report this to the appropriate authority; (d) If you are in therapy by order of a court of law, the results of the treatment ordered must be revealed to the court; (e) Disclosure is required by the Arizona Board of Behavioral Health Examiners; (f) inappropriate or unethical behavior as outlined in the state licensure guidelines by another health care provider (g) to comply with the USA Patriot Act and other federal, state or local laws, and (h) If you are seeking payment through an insurance company, I will be required to reveal confidential information to them (each insurer is different in what information they require).

There may be a time when our paths cross outside of the therapy session. I will maintain your confidentiality by making any gesture to you minimal if at all. It will be understood that you or I are not being rude, simply maintaining the therapeutic boundary. You may approach me if you like, although I will keep conversation minimal, again to maintain your privacy. There may be a time when group members may cross paths of other group members. Keep interaction to a minimum unless desired by both parties. Be respectful to not reveal anything related to group outside of group. It is advised that no content of the group process is posted to any social media platform, as this would result in breaking confidentiality for the entire group.



**Records.** You have a right to review your records and must be requested in writing. Reasonable copy and consultation fees apply. I prefer to give you the documentation in person and discuss the information you request, versus mailing you the documents to minimize the possibility of misinterpretation. I do not keep any “secret notes”, so please do not ask me to do so. Any part of your record in the files can be released to you, or any person or agency you designate so long as all necessary releases of information have been given. Records will only include the patient’s personal progress with the group process and topics discussed. I will tell you at the time whether or not I think releasing the information in question to that person or agency might be harmful in any way to you.

**Availability of Services and Safety.** This practice does not have the capability of providing emergency services or responding immediately to emergencies. I will respond back to you as quickly as possible, however at any given time extenuating circumstances may prohibit this from feeling timely. Emergencies should be directed as appropriate to the respective need. For life threatening emergencies call 911. For mental health emergencies you may contact Maricopa Crisis at (602) 222-9444 or Banner Help Line at (602) 254-4357.

**Other Safety Concerns.** Members of a group may not use drugs or alcohol before or during group. Members of a group should not engage in discussion of group issues outside of group. Members of group should remember that keeping confidentiality allows for an environment where trust can be built and all members may benefit from the safety of being able to participate in the group experience. Your group therapist(s) will monitor discussions and maintain a respectful environment to keep safety and trust a priority.

**Attendance.** Your presence in the group is highly important. A group dynamic is formed that helps create an environment for growth and change. If you are absent from the group, this dynamic suffers and affects the experience of you and other members of the group. Therefore, your therapist (s) would ask that you make this commitment a top priority for the duration of the group. Members will be charged a no-show or late cancellation fee if the absence is not communicated at least 24 hours before the group start time. It is understood that occasionally an emergency may occur that will prevent you from attending group. If you are faced with an emergency or sudden illness, please contact your group therapist (s) before group begins let them know you. Because it usually takes several group sessions for clients to "settle in" and receive the full benefits a therapy group provides, we ask incoming members to make an 8 week commitment. If for any reason you will not be able to complete group, we are asking for a week notice so that you and other group members may have some closure with this group.

**Court Involvement:** More often than not, therapy is not useful in court proceedings. It innately compromises your confidentiality and progress in treatment. Testifying also compromises the underlying principle of therapy that this is a safe place to explore thoughts, feelings and life interactions that have initially led you to believing therapy would helpful and productive. Considering that this is my position on court involvement, if I do receive a subpoena from a judge, I will comply to the nature of my ethical, professional and legal obligation. The fees associated with this process are to be determined at that time and will be assessed by the hour (in 15 min. increments) for any time spent in relation to the case (depositions, phone consults, written summaries and letters, testimony, drive/wait time etc.). Any additional legal counsel needed for the purposes of working through your case or additional representation for the therapist, may also be determined your financial responsibility.

**Financial:** The fee for this group is 40.00 per group session . You are responsible to attend and pay for each session including no-show or late cancellation fees. When a client is a minor, counseling fees are the responsibility of the parent/parents or legal guardian. This practice manages group payments by having a credit card and Payment Agreement form on file. While attendance to group is important for the patient and to the other group members and group process, if you, or your child, is unable to attend the group session, we require 24 hours notice of the absence in order to plan accordingly for the group. If 24 hours notice is not given, a late cancellation or no show fee of 20.00 will be assessed.

*I understand that the therapist has the right to seek legal recourse to collect any unpaid balance. In pursuing this, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.*



**Consent:** I acknowledge that I have read and understand the above information and agree to participate in group therapy. I understand that I am consenting to participate in the group process and if led by an intern or associate, that my treatment will be supervised by Dr. Kimberly Bailey, DBH, LMFT and, understand the methods I may participate in to aid in the supervision process. In the case of a minor child, I hereby affirm that I am the custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

*\*\*In the case of a minor child, please specify the following:*

Full name of minor \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_

Signatures: Patient(s) or Guardians \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date \_\_\_\_\_

Dr. Kimberly Bailey, DBH, LMFT 10-200