ZOE CENTER
Psychotherapy for a Better Life

Informed Consent & Therapy Contract

We feel it is important that, as our client, you are fully informed about the therapy services you will be receiving. Your signature below indicates that you have received, read, and understand the practice policies of the Zoe Center in helping you make an informed decision about entering therapy.

1. I understand that the Zoe Center is a private practice which offers life coaching, counseling, and psychotherapy services according to the laws of the State of Kansas. I understand that Cristinette Likiardopoulos, LCMFT, (hereafter referred to as "therapist") is licensed to practice in the State of Kansas as a Marriage and Family Therapist .
2. I understand the therapist provides therapy to individuals, couples, and families from a systems perspective utilizing therapeutic approaches and models associated with the marriage and family therapy profession.
3. I understand that the therapist is bound by the Code of Ethics set forth by the American Association for Marriage and Family Therapy (AAMFT) and that I can request a copy of those ethics at any time.
4. I understand that, as a client, I have certain rights and those rights have been reviewed with me by my therapist.
5. I understand that, except under specific circumstances mandated by law, communications with my therapist will remain confidential as will any records regarding the therapy process unless I sign an *Authorization & Request for Release of Confidential Information and Privileged Communication Form* authorizing access to the information before any file information will be released in accordance with K.S.A. 65-6410. If more than one family member participates in a session, each and every participating family member must consent prior to the release of the file information. Where a minor is receiving services, the appointment of a *guardian ad litem* may be necessary prior to the release of the minor client's information. The client's family members are not entitled access to client information just because they are family.
6. I understand that, due to legal or ethical obligation, specific circumstances may require my therapist to break confidentiality and report information obtained as a result of the therapy process. Those circumstances exist when: a) a therapist believes a client may be a danger to him or herself or to others; b) the therapist believes that a child, elderly or disabled person may be subject to abuse or neglect; and c) when a court order exists that requires information regarding the therapy process be provided. I understand that any such breaches of my right to confidentiality will be discussed with the therapist's clinical supervisor.
7. I understand that, in the State of Kansas, my therapist is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to symptoms of a mental disorder. In order to complete such a consultation, my therapist will request that I complete a *Authorization & Request for Release of Confidential Information and Privileged Communication Form*, I also understand that I may waive this consultation, in writing, and that the therapist will discuss this process with me at any time if I so request.
8. I understand that there can be risks and benefits associated with therapy and have discussed those with the therapist.
9. I understand that I may leave therapy at any time and agree to discuss the termination of therapy at a regular therapy session.
10. I understand the financial policies of the Zoe Center, LLC and agree to pay $_____ for therapy at the beginning of each session, unless a previous arrangement has been made between the therapist and the client.
11. There will be a returned check fee of $35 for any checks returned from your bank due to insufficient funds. This will be due within 7 business days from the date the check was written.
12. I understand that I will be charged a $50 late cancellation fee if I do not give 24 hours advance notice for a missed appointment. In this situation, if I fail to reschedule and attend my session during the week in which it was originally scheduled, I will be charged a full session fee for the missed appointment since my therapist had reserved that time specifically for me.
13. I understand that I will be charged a rate of $200 per hour, with a four hour minimum, if my therapist is called to testify in court on my behalf, whether or not the services are required once my therapist arrives at the courthouse.
14. I understand that I will be charged a $200 per hour ($50 minimum) handling fee to prepare and send files or paperwork to a third party.
15. I understand if there is no session activity in my file for a period of four weeks my file will be automatically closed. However, my file can be reopened upon completion of a new intake and payment of any balance due.

My signature below indicates that I give my full and informed consent to receive marriage and family therapy services from the Zoe Center, LLC.

Client Signature	Date	Client Signature	Date
Client Signature	Date	Client Signature	Date
Therapist Signature	Date	Therapist Signature	Date