Center for Counseling & Family Therapy
Saint Louis University
3700 Lindell Blvd, Ste 1100, St. Louis, MO 63108

Client I.D.#_____

Statement of Understanding

I understand that therapy services at the Center for Counseling and Family Therapy (CCFT) are provided by couple and family therapy and medical family therapy interns who are graduate students in the Medical Family Therapy Program, Department of Family & Community Medicine, Saint Louis University. Therapist interns have completed a considerable amount of coursework and are accumulating supervised clinical experience. I know that an important part of clinical training involves supervisors observing therapist interns as well as having students observe each other's work, and this is standard practice in a couple and family therapy or medical family therapy education graduate training program. This observation is accomplished by:

- Sessions are recorded for later playback in individual or group supervision sessions.
- Sometimes supervisors and/or students observe therapy sessions from behind a one-way mirror. Of course, any time this is scheduled clients will be informed of such observation prior to the session.

I have been informed that all supervisors are faculty members of the Medical Family Therapy Program and are licensed counselors, marital and family therapists, or psychologists. I also understand that observation and recording of sessions enhances the quality of services and are used to assist the therapist in improving skills and in planning for future sessions.

I have been informed that because the therapist interns and faculty at the CCFT are part of an interdisciplinary department, sometimes students, residents, and faculty from the medical school and allied health professions may observe or be part of a collaborative care team. This may improve my care and aid in the education and training of medical and allied health professionals. Also all observers have been through HIPAA training and understand the confidential nature of therapy.

I understand that there is an expectation that I will benefit from therapy but there is no guarantee that this will occur. Nor is there a guarantee concerning the duration of treatment. Therapy may deal with sensitive or difficult topics, may elicit uncomfortable emotions and may lead to decisions that are, at least temporarily, disruptive for myself, and/or my family. I understand that I can inquire about the nature, length, cost, and consequences of my therapy at any time and that I am free to discontinue treatment at any time.

Confidentiality

All information disclosed within therapy sessions is confidential and will not be revealed to anyone outside the supervision team without written permission, except as required by law. All recordings will be considered confidential by students and faculty for the purposes of training, supervision, and research (as communicated by informed consent prior to release of information). Circumstances may arise requiring the release of confidential information. These circumstances are listed below.

- If you are deemed in danger of harming yourself or anyone else;
- If the therapist believes that a child or elder is being abused;
- If the client is a minor (under 18 years of age), the client does not have a legal right to keep therapy confidential from his/her parents. (For purposes of therapy, however, the parent may agree to grant the minor privacy in therapy); or

- If the court subpoenas the records as they relate to court proceedings.
- If you signed an additional informed consent document for taking part in a research study as part of your care. This will be a separate document you will sign at the time of services.

After Hours Contact/Emergencies

The operating hours of the Center for Counseling and Family Therapy are Monday 4:00 P.M. - 9:00 P.M. and Tuesday - Thursday, 9:00 A.M. - 9:00 P.M. The Center for Counseling and Family Therapy is not equipped to offer emergency treatment after hours or on a walk-in basis. In the event of a crisis after hours, on the weekend or other times when the CCFT may be closed you can:

- Go to the emergency room of the nearest hospital.
- Call SLU Hospital (for adults) 314.977.4850 or Cardinal Glennon Hospital (for children) 314.977.5600.
- Call the Life Crisis Hot line (647-4357) and speak with a counselor by phone.
- Call or message the Trevor Project for LGBTQ-affirming counselors to talk to at 866.488.7386 or thetrevorproject.org

Fees

I agree to pay $_____ each therapy session. The fee is established with your therapist in the first session of therapy. Payment for sessions is due at the time of the appointment. Any need for accommodation of fee should be discussed with your therapist.

Cancellations and Missed Appointments

The Center for Counseling and Family Therapy policy requires payment for missed sessions (no shows). Twenty-four (24) hours notice to cancel an appointment is required. If notice is less than 24 hours, I will be responsible for paying for the session.

Contacting Therapist Interns

I may call the Center for Counseling and Family Therapy during normal office hours and leave a message for my therapist intern. The CCFT staff will make sure the therapist intern receives the message in a timely fashion. Furthermore, messages can be left directly on therapists' voicemails on the following telephone numbers: 977-8179 and 977-2195 (please speak with your individual therapist to confirm voicemail number).

I agree to participate in therapy at CCFT under the conditions described above. My signature authorizes the CCFT to use any recording made of my therapy (or transcribed portions and a case description) for the purposes of: (a) evaluation by the therapist or supervisor; (b) consultation with other clinical colleagues; or (c) presentation to professionals who are bound to honor confidentiality. I understand that in all situations, a code number or made up name will be used and other identifying information will be changed. Further, I understand the purpose and potential benefit of recordings and supervision of my therapy services and I voluntarily consent and agree to their use.

To be signed by all participating members:

Print Client Name/Legally Authorized Person	Signature	Relationship to Client	Date
Print Client Name/Legally Authorized Person	**Signature**	**Relationship to Client**	**Date**
Print Client Name/Legally Authorized Person	**Signature**	**Relationship to Client**	**Date**
Print Client Name/Legally Authorized Person	**Signature**	**Relationship to Client**	**Date**
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