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INFORMATION, AUTHORIZATION, & CONSENT TO BEING A COLLATERAL PARTICIPANT

Thank you very much for taking the time to read this authorization form carefully. **I have given you this form because you have elected to become part of your friend's, family member's, spouse's, or partner's treatment.** Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your experience in joining the therapeutic process. Specifically, this document is to inform you about your rights, responsibilities, and risks regarding collateral participation. A "collateral participant," means that **you are here to assist another person (the designated client), but you are not the primary focus of treatment. P**lease know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your collateral participation.

Background Information

I received my undergraduate Bachelor Arts degree in Psychology from Tel Aviv University in 2000, became an NLP Master practitioner in 2007, and am a student in the Masters of Arts in Marriage and Family Therapy program at NorthCentral University of Arizona, with Medical Family Specialty. I have been providing therapeutic services to adolescents, families and social support groups as part of my studies since 2018. My professional experiences include a suicide prevention online hotline, emotional support in a veterinarian hospital, independent work as an NLP Master Practitioner, and grief work. I am currently contracted with Cornerstone Family Services (CFS) to provide outpatient mental health counseling services under the direction and supervision of Jennifer D. Vann MS, LMFT, owner of Cornerstone Family Services. I also receive supervision from Dr. Kara McDaniel, LPC, NCC, BC-TMH and take part in a supervision group in my school, led by a clinical faculty member.

Theoretical Views and Client Participation

I believe that a therapeutic relationship is based on a collaborative partnership between my clients and me. You are unique and so are your goals and your journey toward them. I am an incurable optimist and believe that we all have all the resources we need to be our best selves. In our sessions, I want to create a safe environment for you to set your own goals, express your best hopes and explore them with me. I work systemically from an integrative approach combined primarily from solution-focused, collaborative and narrative therapeutic techniques, focusing on your strengths. However, I will incorporate interventions from additional modalities as I see fit, adjusting them to your needs. I believe that it is my job as a therapist to see you as your exceptional best self, even when you don't. It is important to me that you to share your feedback around questions which you feel uncomfortable with. If you are unsatisfied with the direction of therapeutic services, I ask that you share your thoughts with me, so we can explore them together. I am honored to be allowed to walk part of your journey by your side.

Description of Collateral Participation

The role of a collateral participant can vary greatly. For example, a parent or guardian may continuously be involved in the treatment of a minor, whereas, a partner or friend may only come in once or twice to help the designated client. We will discuss what role you shall take in the client's treatment during our first session. As mentioned above, I am committed to providing treatment to the designated client, and your participation is adjunct to this treatment. Therefore, **my legal and ethical responsibility resides strictly with the designated client.** This means the following: (1) What the client tells me is confidential, but what you tell me is not. This isn't to say that I plan to divulge any information that you tell me to the public. However, I will not keep secrets from the client, and your information isn't protected by the same laws that the information given to me by the client is. (2) Although your participation as a collateral may help you psychologically; it also may not. **My primary concern is for the client, and treatment will focus on the client's needs.** However, I will be glad to give you other resources for your own treatment if necessary. (3) I will keep a clinical record for the designated client only. *Any notes I take regarding your participation will go into the client's chart.* The client has the right to access his/her chart, whereas, you do not have the right to access this chart without the client's written permission. Parents have a legal right to a minor's chart, but not an ethical right. (4) I will give the client a diagnosis for treatment purposes and, if applicable, for insurance filing. However, I will not give a collateral participant any kind of diagnosis.

Parents as Collateral Participants (if applicable)

Due to the sensitive nature of counseling and the fragile stage of development that your child is currently experiencing, forming a therapeutic bond with me, as their therapist, is very critical at this point. It is important that your child feel safe and comfortable discussing personal and private topics with me. In effort to respect the privacy and sensitive needs of your child, I will not be discussing the content of therapy sessions with you in detail. It is my hope that through the therapeutic process new skills and insights will be gained by your child, so they can discuss these sensitive topics with you in their own time. If your child is too young to do this, we will definitely have family meetings to assist in this process. However, if at any time I make the assessment that your child is in danger or might be dangerous to others, if abuse/neglect is suspected or reported, or if there are any other concerns related to the health and welfare of your child, you will be notified immediately so that the necessary actions and precautions can be taken.

Confidentiality & Records

As mentioned above, your communications with me will become part of a clinical record of treatment for the designated client, and it is referred to as the client's Protected Health Information (PHI), protected by both federal and state law. The PHI will be kept in a file stored in a locked cabinet in a locked office. Additionally, the PHI of the client is confidential, with the following exceptions: (1) the client directs me to tell someone else and signs a “Release of Information” form; (2) I determine that the client or you are a danger to yourself or to others; (3) the client or you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; (4) the sessions are being billed to an insurance company, and the client's insurance company requires me to submit information about treatment for claims processing or utilization review; or (5) I am ordered by a judge to disclose information. Regarding an order by a judge, my license does provide me with the ability to uphold what is legally termed “privileged communication.” Privileged communication is the client's right to have a confidential relationship with a therapist. This state has a very good track record in respecting this legal right. If for some unusual reason a judge were to order the disclosure of the client's private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what the client says confidential. However, you

should be aware that if a judge orders the disclosure of your information, **I do not have the legal authority to maintain your confidentiality**. I only maintain that authority with the designated client. Additionally, it is expected that you will maintain the confidentiality of the client in your role as a collateral participant. If at any point we, as a team, determine that family or couples therapy is more appropriate than collateral participation, then you will be afforded all the rights to confidentiality that currently reside with the designated client. Please feel free to discuss this with me if you have concerns.

Structure and Cost of Sessions

Each therapy session lasts 45-50 minutes. As a collateral participant, you will be invited into therapy session(s) in order to assist in the client's treatment. As such, the client and/or client's parent/guardian is financially responsible for session payments.

Cancellation Policy

As a collateral participant, the client and myself expect you to attend all scheduled sessions in order to assist in the client's treatment. I understand that "life happens" and that unexpected interruptions occur particularly with children and adolescents, but I do expect you to inform the client if you will not be able to attend a scheduled session. If you need to cancel your appointment, please inform the client **NO LATER THAN 24 HOURS PRIOR** to your scheduled appointment. The client is financially responsible and will be charged the full session fee that is cancelled with less than 24 hours notice. Cornerstone Family Services requires all clients to provide a credit card number to keep on file in the case of missed or cancelled appointments. This information is kept in a confidential file that is locked at all times. If you "no show" or cancel your appointment without giving a 24-hour notification to the client, the cancellation charge will be charged to the client's card. Please note that insurance companies do not reimburse for missed appointments.

Social Media

I am restricted by the Code of Ethics by which I abide from entering into dual relationships with clients except in very limited circumstances where these relationships would be beneficial to you. "Dual relationship" means any relationship outside of our therapeutic relationship. To abide by this code, I am not able to accept any requests to friend, like, or otherwise connect via the web or social media sites such as Facebook, LinkedIn, and Twitter.

Protecting Your Privacy

To protect your privacy, if we happen to see each other outside of session I will not initiate contact (e.g. say hello, indicate we know one another) unless you choose to do so first.

Supervision

Supervision helps to ensure that you and your family are receiving the best of care and that appropriate measures are being taken to ensure that your needs are being met. I have contracted with a State Board approved supervisor to oversee cases that I feel the need to seek guidance on. This supervisor is legally bound to all the confidentiality restrictions listed above. Your case may or may not be discussed with a supervisor at some point during your work with me. During supervision I do not disclose names of clients or specific identifying information. If you have any questions about this process you are encouraged to ask them at any point during your time in therapy. Director and Supervisor Jennifer D. Vann MS, LMFT and Supervisor Dr. Kara McDaniel, LPC, NCC, BC-TMH.

Internship

In addition to said supervision and as part of my internship, I attend weekly group supervision with Northcentral University. These groups are held by a faculty member. This group is legally bound to all the confidentiality restrictions listed above. Your case may or may not be discussed with a supervisor at some point during your work with me. During supervision I do not disclose names of clients or specific identifying information.

Emergencies

Shirley Shani Ben-Zvi, MFT Intern does not provide emergency services. I do not carry a pager and I am not available at all times. If this does not feel like it will be sufficient support for you, please inform me and we can discuss additional resources or transfer your case to a therapist or clinic that has 24-hour availability. Generally, I will return phone calls within 24-48 hours. Should I be out of town, I will make every effort to alert you of my absences. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one of more of the following:

1) Call Ridgeview Institute at 770.242.4567 or Peachford Hospital at 770.454.5589 2) Call 911
3) Go to the emergency room of your choice
4) Cobb County Mental Health Crisis Line 770.422.0202
5) Fulton County Mental Health Crisis Line 404.730.1600

Ethical Considerations

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Association for Marriage and Family Therapy. I make it a priority to be familiar with the AAMFT Code of Ethics and to structure my practice to follow those guidelines. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the Georgia Association for Marriage and Family Therapy and the American Association for Marriage and Family Therapy, both which govern my profession.

In order to maintain ethical standards, I find it helpful to occasionally consult with other professionals. In these consultations I do not reveal the identity of my client(s). The consultant is also bound to keep any information about a case confidential by the ethical standards of their own professional association. I do not consult with therapists who are not bound by such ethical standards.

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****Please keep the above information for your record. Return only this page.****

Our Agreement to Enter into a Collateral Relationship

I sincerely hope this document has been helpful to explain your role in the client's treatment, your rights, risks, and my procedures. If you have any questions about any part of this document, please ask.

Please print, date, and sign your name below indicating that you have read (or have had read to you) and understand the contents of this document and you agree to the policies stated above.

Designated Client's Name (Please Print)	Date	Designated Client's Signature
Collateral Participant's Name (Please Print)	Date	Collateral Participant's Signature

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

Therapist's Name (Please Print)	Date	Therapist's Signature

Informed Consent

General Information

This Informed Consent document supplements the regular informed consent you have already been given by this treatment facility.

You are receiving therapeutic services from a therapist who is currently enrolled in a marriage and family therapy training program at Northcentral University (NCU). NCU is an education and research institution and provides both standard and advanced education and training in marriage and family therapy (MFT). Our goal is to provide guidance and support through supervision of all trainees as they offer consistent and professionally competent services for their clients. To accomplish this goal, we routinely use video recording and direct supervision through secure online video conferencing, including review of video recordings of therapy sessions. Video recording, supervision, and consultation are standard practices in MFT training and education throughout the profession, and are used to assist the therapist in improving skills and in planning for future sessions. Just as importantly, these tools help us, the therapist's clinical supervisors, ensure that you are receiving the best possible care.

As a research institution, we are interested in finding out how therapy benefits families such as yours. Your therapist's case notes and video recordings may be used as one basis for possible future research to better understand the therapeutic process, which may benefit you and others in similar situations. You and/or members of your family may be asked to fill out questionnaires before you begin therapy and then again later in therapy. Please know that if any of this material should be used in a research project, you will not be personally identified in any way. You should also know that all research at Northcentral University is reviewed by the Institutional Research Board to ensure that the ethical rights of clients are properly respected and protected.

Video recordings are treated in a way to ensure that they remain confidential. They are not shared in any way not specifically addressed in this Informed Consent. We hope this information helps you understand our method of operation and the reasons behind it. Do not hesitate to ask questions or discuss any part of our procedures with your therapist. You may also contact the MFT Director of Clinical Training at Northcentral University at 888-628-6911 ext. 8154, or via email at mft@ncu.edu, if you have any additional questions.

Confidentiality

Your case records, including videotapes, will be kept confidential and private unless disclosure is authorized or required by law. Within the limits of this confidentiality agreement, your therapist may discuss and review your case information with a local supervisor, and with a supervising faculty member and a supervision group at Northcentral University. All NCU supervisors and participants in the supervision group have committed to uphold the MFT professional standard of confidentiality. Additionally, every possible effort is taken by your therapist to limit the disclosure of any identifying information. All supervisors and therapists who are granted access to this confidential material are bound by the same ethical standards of confidentiality as your primary therapist. Your treatment facility's primary informed consent will provide you with information about other limits to confidentiality as set forth in your state laws.

Consent

I voluntarily consent to receive therapy services or have my child accept services provided by Shirley Shani-Ben Zvi. I understand that my therapist is a marriage and family therapist in training under the supervision of clinical faculty. I further understand that Northcentral University is a teaching program.

I understand the purpose and potential benefit of questionnaires, videotaping, and supervision of my therapy services, and I voluntarily consent and agree to their use.

I understand that this consent to services will be valid and remain in effect as long as I attend therapy sessions unless revoked by me in writing, with written notice provided to my therapist. If I have any questions or concerns now or in the future, I understand that I should consult with my therapist or the MFT Director of Clinical Training at NCU (928-541-8186).

I certify that this form, including the statements on the limits of confidentiality, has been fully explained to me, that I have read it or had it read to me, and that I understand its contents. I certify that I have legal authority to give consent for the treatment of all minor children that are included in therapy.

Date	
X	
Signature of Client or Other Legally Authorized Person	Print Name and Relationship to Client
X	
Signature of Client or Other Legally Authorized Person	Print Name and Relationship to Client
X	
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Northcentral University

RELEASE AND PERMISSION TO TAPE

Video and audio recordings are routinely used at Northcentral University to help us ensure the quality of services our students provide you, their client(s). It is necessary for us to have your written permission to use these electronic helpers. Should you refuse permission, you should be aware that our student must still make written and/or verbal case reports on all clients to their clinical supervisor. If you refuse to allow our student to discuss your case with his/her clinical supervisor, our student will be unable to provide treatment for you.

I (We), the undersigned, do consent to the video and/or audio recording of my (our) therapy sessions. This consent is being given in consideration of the professional services being rendered by the intern to me at this facility. I (We) understand that I (we) may request the recording to be turned off or erased at any time during the session. I (We) understand that the recording may be reviewed by my therapist's clinical supervisor and by other advanced therapy interns. I (We) are aware that the clinical supervisor and others who may listen to these sessions are bound by the same rules of confidentiality as my therapist and that the purpose of these recordings is to ensure the quality of care that I (we) receive. These recordings will be stored in a manner to ensure their security and my confidentiality, and they will be destroyed at the earliest time that they are no longer needed.

I (We), the undersigned, acknowledge that the purpose and value of taping has been fully explained to me (us) and that my (our) consent to such taping is given freely and voluntarily.

Date

X

Signature of Client or Other Legally Authorized Person

Print Name and Relationship to Client

X

Signature of Client or Other Legally Authorized Person

Print Name and Relationship to Client

X

Signature of Client or Other Legally Authorized Person

Print Name and Relationship to Client

X

Signature of Client or Other Legally Authorized Person

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