Kim Sullivan, LMFT
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Informed Consent for Treatment

I agree to voluntarily enter into mental health treatment with Kim Sullivan, LMFT. I understand that I am participating in a specialized form of therapy known as Dialectical Behavior Therapy (DBT) that consists of both skills groups and individual therapy. I understand that I will be expected to complete homework as a key component of this therapy.

I understand that all information shared with my therapist is confidential and no information will be released without my consent. Consent will be provided in written form via Release of Information to speak with my doctors or family. With that said, there are some limits to confidentiality, and the therapist is obligated to breach confidentiality in the following situations:

- If the treatment provider has good reason to believe that I may harm another person or myself, the clinician is ethically bound to take necessary steps to prevent such danger.
- If the treatment provider has good reason to believe that a child is being physically or sexually abused or is being neglected, the clinician is legally required to take steps to protect the child and inform the proper authorities.
- If the treatment provider has good reason to believe that an elder adult (age 65 or older) or a dependent adult (age 18-64 who have physical or mental limitations that restrict their ability) is being physically or financially abused, neglected, abandoned, or receiving other treatment that results in physical harm, pain, or mental suffering, the clinician is bound to alert the proper authorities to investigate.
- When a valid court order is issued or a request from Homeland Security is received, the clinician is bound by law to comply with such requests.

Psychotherapy may provide significant benefits, but it may also pose risks. Benefits may include relief from symptoms and /or improvement in social, interpersonal, occupational, or educational functioning. The risks may include eliciting uncomfortable thoughts and feelings or recalling troubling memories. Additionally, risks may involve changing the nature of relationships with significant people and perhaps ending relationships such as marriages.

By signing below, I am agreeing to participate in treatment services provided by Kim Sullivan, LMFT. I have the right to refuse to participate in treatment and I may withdraw my consent and stop participating at any time. If I have any questions regarding this consent form or about services offered, I may discuss them with my therapist. I am able to respond knowingly and intelligently to questions about my treatment and I am able to participate in decisions about my treatment. I have read and fully understand the above and have had the opportunity to ask any questions that I have, and have had my questions answered.

_____ _____

Print Client Name Client Phone Number

_____ _____

Client Signature Date