

Good Life Center for Mental Health, LLC

Client Advisement for Exposure Treatment

The following information clarifies issues relevant to the professional practice of exposure treatment. This will serve as an addendum to the Client Therapist Agreement/Informed Consent when exposure therapy is indicated.

Exposure therapy is the treatment of choice for anxiety. It involves therapists working with clients to confront feared objects, situations, contexts, and/or people. All exposures are designed to be safe and non-threatening with the goal of having clients experience emotional discomfort typically associated with these experiences. The rationale for exposure is to help clients realize that their intensity of anxiety is exaggerated and that they can effectively manage their emotional reaction to the situation.

Please review the items below and discuss any questions or concerns with your therapist. Please initial each statement to acknowledge that you understand and agree with what is stated.

_____ I have been seen by a medical professional who has determined that I do not have any medical conditions that are contraindicated to the use of exposure treatment.

_____ I acknowledge that my therapist may ask me to engage in specific exercises or activities that I have been avoiding due to the sensations or fear I experience while doing them.

_____ I understand that I may experience anxiety and fear, which is the purpose for this treatment, but will not be put in a situation against my will, nor exposed to danger beyond what is experienced by anyone in their day-to-day life.

_____ Even though I can stop at anytime, my therapist will encourage me to continue to experience my discomfort or fear, as this will be necessary for symptom improvement.

_____ I understand that even if sessions are held outside of the office, my therapist will provide the same level of care, affording me the same rights and protections.

_____ If sessions are held outside the office, I consent to have my therapist be in public with me. I understand that confidentiality will be a priority but may not be absolute.

_____ I acknowledge that I will use my insurance (personal, automobile) to place claims to cover any damages, injury to self or others that may occur before, during, or after the session.

_____ I agree that Good Life Center for Mental Health, LLC and your therapist will not be held liable for any and all potential damages that may occur due to the actions of the patient or others.

_____ I understand and accept that I will be charged for my therapist's time, which includes travel time.

I have read and agree to above and provide my agreement to participate in exposure therapy.

_____ Date _____

Minor's Signature (For children 14 and over)

Client's Printed Name (Parent/Guardian for Minors)

Date_____

Client Signature (Parent/Guardian for Minors)

2nd Parent/Guardian Printed Name

Date_____

2nd Parent/Guardian Signature (If applicable)