THERAPEUTIC CONTRACT
For Gail Liguore MS, LMFT

The Therapy Process:
Participating in therapy can help you overcome obstacles to growth. This therapeutic process also focuses on your relationship to others in your life. By engaging in psychotherapy you have the opportunity to learn about yourself and to begin to make better choices. It is a place to understand who you are and to gain the knowledge to make desired changes in yourself and your present situation. Through this process you begin to develop increased self esteem and then can grow, heal, and change.

I consider therapy a collaborative endeavor that has the possibility to uncover the unconscious motivations that keep us from achieving our true potential. Together, we will create a working atmosphere of respect, kindness and acceptance in an open and judgment-free setting where you will find a safe environment in which to explore and understand your most difficult feelings, patterns, and habits. You may find that once the relationship between past experience and present behavior is examined and realized, it will be possible to the move forward to make change in your life. Therapy is an encouraging, judgment free, and confidential sanctuary where you can feel free to discuss your feelings, hopes, disappointments, relationships, problems, and fears.

My Therapeutic approach includes several techniques. These include: **Cognitive - Behavioral Therapy** (CBT) which is a practical approach emphasizing learning to recognize and change maladaptive thought patterns and behaviors, improve how feelings and worries are handled, and break the cycle of dysfunctional habitual behaviors. This perspective helps people see the connection between how they think, what they tell themselves, and the feelings and actions that follow.
The **psychodynamic** approach focuses on understanding where the patient's problems or symptoms came from. The therapist helps the patient recognize how the past is repeated in the present. **Family Therapy** is used to treat a family system rather than individual members of the family. A form of Systemic Therapy, **Eclectic Therapy**: When therapists are asked their theoretical orientation, this is the answer most often given. This is essentially a common sense approach to

helping people by tailoring therapy to the needs of the individual client. **Rational emotive behavior therapy** focuses on uncovering irrational beliefs which may lead to unhealthy negative emotions and replacing them with more productive rational alternatives. **Relationship Therapy** enables the parties in a relationship to recognize repeating patterns of distress and to understand and manage troublesome differences that they are experiencing. **HUMANISTIC AND INTEGRATIVE PSYCHOTHERAPY:** Clients are invited to develop their awareness as to what prevents them from unfolding their own true nature in the inner and outer expressions of their life. This is when several distinct models of counseling and psychotherapy are used together. **Client-centered therapy** is a non-directive technique developed by humanist psychologist Carl Rogers that emphasizes the importance of unconditional positive. **Group Therapy** Effective group therapy can help clients enhance self responsibility, increase readiness for change, build support for recovery and change, acknowledge destructive behaviors, and cope with personal discomfort. And **SYSTEMIC FAMILY THERAPY** Systemic Family Therapy incorporates individual, couple and family therapy. Other techniques used are guided imagery and relaxation techniques.

Client's rights: You have the right to a confidential relationship with me. Within certain legal limits (see #3), information reveled by you during the course of therapy will be kept completely confidential and will not be reveled to any person without your written permission.

1. You have the right to know the content of your records at any time, and I have the right to provide you with either the complete records or a summary of their contents.
2. If you ask me, I can release any part of your records on file with me to any person you specify. I will tell you when you make your request whether or not I think releasing that information to that agency or person might be harmful to you at any time.
3. Under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situation include:

a. If you reveal information to me about active child abuse or neglect, elder abuse, or dependent physical abuse, I must make a report to protective services. When a perpetrator of child abuse is in contact with minors and there is a reasonable suspicion that he or she may still be abusing minors, I must also report that information.

b. If you seriously threaten harm or death to another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies.
c. If you are in therapy or being tested due to an order of a court or lawyer, the results of the treatment or tests ordered must be revealed to that court or lawyer.
d. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena.
e. If you are in a lawsuit where emotional harm is being claimed, the opposing side may subpoena your therapy records.

4. You have the right to ask questions about any of the procedures used in the course of your therapy. If you ask, I will explain my customary approach and methods to you.
5. You have the right to choose not to receive therapy from me. If you choose this, I will provide you with the names of other qualified professionals whose services you might prefer.
6. You have the right to terminate therapy with me at any time without any financial, legal, or moral obligations other than those you've already incurred. I have the right to terminate therapy with you under the following conditions.

a. When I believe that therapy is no longer beneficial to you.
b. When you fail to follow recommended treatment.
c. When you believe that you will be better served by another professional.
d. When you have not paid for the last two sessions, unless special arrangements have been made with me.
e. When you have failed to show up for your last two therapy sessions without a 24- hour notice. If there has been a misunderstanding, please call.
f. For all Victim Witness Clients: If you have a scheduled appointment and do not give a 24 hour notice before canceling Central Coast Counseling Center will bill you $45.00 for the therapist's lost time.
g. Tricare/Triwest clients can also be charged a $45.00 no show fee.
h. If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have a written consent, I will provide that professional with information they request.

If any of these situations apply, I will send you a certified letter to your address of record to inform you of my decision and I will give you the names of several therapists for your future counseling needs. If I have written consent I will provide that professional with the information they request in writing. As life can bring unexpected circumstances, should I be unable to continue your therapy, my colleague Mary Jo Pedersen, LMFT will contact you to discuss what would be

best for you at that time.
I agree to pay the fee of $ 140.00 for each completed fifty minute session. I will make payment in cash, credit card or by check at the time of the therapy appointment, unless we have other arrangements. I understand that I can leave therapy at any time and that I have no financial, legal, or moral obligation to complete the maximum number of sessions listed in this contract. I am contracting only to pay for completed therapy sessions, or for any session I miss without providing 24-hour notice, and for telephone time as outlined in the Office Policies section.
Date_____/_____/_____ Client's Signature_____

Date_____/_____/_____ Therapist's Signature_____

Consent for Treatment:

I, _____
Authorize and request that Gail Liguore LMFT**,** carry out psychotherapeutic examinations, diagnostic procedures, and/or treatment which now or during the course of my care as a patient are advisable. I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read and fully understand this Consent for Treatment form.
Date_____/_____/_____ Client's Signature_____

Date_____/_____/_____ Therapist's Signature_____

OFFICE POLICIES

Payment for Service: You are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify me if any problem arises regarding your ability to make a timely payment.
Cancellations: Since an appointment reserves time specifically for you, a minimum of 24-hour notice is required for rescheduling or canceling of an appointment. Without notification of an emergency such as an illness or accident, $45.00 no show fee will be charged to your account for missed sessions.
Office Hours: My office hours are from 11am until 6:30pm (with 5:30pm being the last scheduled session) Monday through Friday. If you need to contact me between sessions, please leave a message and I will return your call.
Telephone Time: After 15 minutes of telephone time, you will be charged a prorated fee.

Session Lengths: Sessions are 45 to 50 minutes long, beginning at the scheduled time of appointment, which include filling out forms required for therapist information, and HIPAA law. Due to unforeseen circumstances before session a 10-15 minute leeway for therapists is expected.
Couples/Families/Group Sessions can run from 1.5 to 2 hours.
Sessions Greater Than 50 Minutes: Sessions that go beyond the fifty minutes will be prorated to the nearest quarter hour, unless you have made prior arrangements with me.
Emergency Procedure: An emergency is an unexpected event that requires immediate attention. If an emergency situation arises, please state this when you leave your message, and I will return your call as soon as possible. You can also call the 24-Hour Crisis Helpline (**THE NEW CRISIS PHONE NUMBER IS 211**) Cell phones use 1-800-400-1572. If the emergency requires it, please go to your local hospital's Emergency Room and then follow-up with your physician.

I have read and understand these office policies.
Date_____/_____/_____ Client's signature_____
Date_____/_____/_____ Therapist's Signature_____