

Dr. Laura Richter, Ph.D., LMFT  
**Informed Consent for Therapeutic Services**

Welcome to my practice. This document contains important information that will help you understand your rights as a client and what to expect in relationship to the services I provide to you. This document replaces or supersedes any previous informed consent agreement you may have entered into for services provided by Laura Richter, Ph.D., LMFT.

Please read this document carefully prior to signing and beginning services. This form must be signed by all individuals age 18 years of age and older who will be attending therapy. If you have any questions regarding this document, please contact Dr. Laura Richter at 561 715-6404 or [email Drlaurarichter@gmail.com](mailto:Drlaurarichter@gmail.com) before signing.

**About Dr. Richter**

Dr. Laura Richter is licensed with the State of Florida as a Marriage and Family Therapist (MT2602). She is also trained as a qualified parenting coordinator for the State of Florida as well as a Collaborative Divorce Neutral Mental Health Professional. Dr. Richter has experience working with individuals, couples and families. Areas of specialization include but are not limited to individual issues, couples counseling (infidelity, communication, sexual intimacy), co-parenting after and during divorce, divorce recovery, grief and loss, depression and anxiety.

**Risks/Benefits to Therapy**

Therapy is an intensely personal process. In order to be most successful in therapy, you will be required to be active and involved in the process. Sometimes therapy can be painful and bring unpleasant memories or emotions to the surface. While there are no guarantees, what you will gain from therapy will be directly related to how open you are to the process and how motivated you are for change and growth. Progress may happen slowly. If at any time you feel uncomfortable with the process and wish to terminate our therapeutic relationship, you may do so. At that time, I will be happy to provide you with the names of other therapists or professionals with whom you may wish to consult.

The ultimate goal of therapy is to help you improve your quality of life by assisting you in developing better coping skills; assist you in seeing issues and problems from different perspectives, in order to improve your communication skills; provide you with support while you are going through a challenging time; and help to reduce symptoms of mental health disorders that you may be experiencing.

**Confidentiality**

You have a right to confidentiality, whereby, information revealed to me during individual, couples, and/or family therapy will be kept strictly confidential and will not be revealed to anyone outside of the individual/couples, and or family therapy sessions without written authorization EXCEPT when otherwise required by federal or state law. I am required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. I am also required to respond if I receive a court order or subpoena, I may be required to release some information. In such a case, I will consult with other professionals and limit the release to only what is necessary by law.

If you wish to have information released, you will be required to sign a consent form before such information will be released.

Initials: \_\_\_\_\_

While I am committed to preserving your right to confidentiality within the limitations of the law, when working with couples, my goal is to advocate for the goals of the couple. There may be times when individual sessions become necessary to further the therapeutic process. In these situations, I will do my best to maintain the confidentiality of the individual. However, I reserve the right to terminate therapy if I deem that what is said in confidence may be contrary or detrimental to the therapeutic process and the goals of treatment. If this should occur, I will advise you that therapy can no longer be continued, based on specific disclosures, and I will refer you to another therapist.

### **Crisis Procedures**

It is important that you understand that this private practice is NOT a crisis center. Our office hours are provided below.

Monday through Friday: 9 a.m. to 6 p.m.

Saturday: Closed

Sunday: Closed

If you call or text the practice number after hours, your phone call will not be returned until the following business day. If you are experiencing a medical emergency, emotional crisis, domestic violence, or any other event that requires immediate attention, you should call 911, 211, or go to your closest emergency room. Below is a list of community resources that you may contact.

(See next page)

911	Community Crisis Services	Open 24hour/day, 7 days/week
211	Essential Community Services	Open 24 hours/day, 7 days/week
561 637-2102	South County Mental Health Center, Mobile Crisis Team/ Emergency Screening	Open 24 hours/day, 7 days/week
1-800-355-8547	Aid to Victims of Domestic Abuse Hotline	Open 24 hours/day, 7 days/week
1-800-273-8255	Suicide Prevention Lifeline	Open 24 hours/day, 7 days/week
1-800-784-2433	Suicide Prevention Lifeline	Open 24 hours/day, 7 days/week

### **The Use of Technology**

In this day and age, technology (e.g., texting and email) is often used as a means of communication. Some clients may choose to use technology to communicate with this office for appointments or questions or concerns. To be clear, texting or emailing is offered as a convenience and used only to schedule, confirm or change appointments. It is not meant to be a platform in which therapy is conducted. Again, this office is NOT a crisis center. Texting and emails conform to the same office hours (provided above) as phone calls. This means that texts or emails may not be responded to until the next business day.

If you choose to text or email about non-emergency services, please be advised that I will take every precaution to safeguard your information. My computer and private practice phone are password-protected; but I cannot guarantee that unauthorized access to electronic communications will not occur. This includes but is not limited to online counseling via Zoom, telephone, email, text or chat. Please be advised that you should also take precautions with regard to authorized and

Initials: \_\_\_\_\_

unauthorized access to any technology. Be aware of any friends, family members, significant others or co-workers who may have access to your computer, phone or other technology used in your counseling sessions.

**Tele-therapy.** Due to the current conditions relating to COVID 19, you may be receiving treatment via Tele-therapy. Tele-therapy involves the use of electronic, internet-based platforms to conduct therapy sessions. Just as is the case with face to face therapy sessions, the laws that protect privacy and the confidentiality of your personal information also apply to tele-therapy sessions. On my end, I am conducting sessions in a private office either within my home or at my professional office. Just as is the case in face to face sessions, therapy notes are hand-written and kept in locked files. Any data that is generated via computer (e.g. emails for appointments, exchanging of documentation) is generated through my password protected computer. No information is shared with others, unless you have given written approval to do so.

In agreeing to conduct online sessions via the Zoom platform, all participants in the therapeutic process agree to the following:

- a. No one will audio or video record any online sessions. We will check with each other that none of us nor anyone on your behalf, has done so.
- b. If a video link is lost, we will all wait for the host to re-send the invitation to rejoin the online session.
- c. We may end online video meetings if there is inadequate quality of connection or a breach of this agreement may have occurred.
- d. We may suspend the session if there is any remote interruption and will restart the online session at a agreed upon date and time.
- e. Only the people who have signed the Informed Consent may be present in the meeting room. We will all confirm that we cannot be overheard from our locations.
- f. We agree to do all we can to ensure that we are not interrupted during the online video session by anyone else such as children, relatives, pets, deliveries. But if we are interrupted, we will all wait quietly until the interruption is dealt with.
- g. We agree to turn off or put to silent any phones, tablets or computers, and disable any alerts announcements or notifications of texts, emails, tweets or other social media activity, and close all or any other open application.
- h. We all agree to turn off any music or radio or background noise.
- i. We all agree to there being no live or deferred video or audio relay of the online session to third participants.
- j. If you create any video or audio recording of the online session, inadvertently or otherwise, you will destroy any such recording as soon as you become aware of its existence.

If you have any questions about any matters of confidentiality, I will be happy to address them.

### **Insurance**

I work out of network with insurance panels. This means that you are responsible for payment of your session fees at the time of service and then you may submit those fees to your insurance company for reimbursement. It is your responsibility to check with your insurance company to determine out-of-network benefits. If you choose to submit your session fees to your insurance company for reimbursement, I will be happy to provide you with a monthly invoice to submit to your insurance company. At the same time, I will ask you to sign a Release of Information Form, should your insurance company contact me requesting any information. Without this release, I will not be able to provide any information relative to your treatment or billing. Relational Consultants Group, Inc. makes no representations and takes no responsibility for how your insurance company reimburses you.

Initials: \_\_\_\_\_

**Payment and Cancellation Policy**

Please note that all payments are due at the time of your scheduled appointment. A minimum of 24 hours' notice is required for cancellation of your appointment. If you are not able to cancel prior to 24 hours, you will be charged for the full session fee. To this end, a credit card imprint is taken at the time you reserve your initial session appointment. This credit card is kept on file and is used in accordance with this policy.

**Clients Rights and Responsibilities**

You have a right to a complete description and explanation of my therapy methods. You have a right to refuse and/or terminate treatment at any time without moral, legal, or financial obligations other than those that have already accrued. If you do, I will provide you with referrals for other professionals whose services you might prefer.

I look forward to working with you toward reaching your goals in therapy. If you have any questions about any of the above, please feel free to ask. By signing below, you are agreeing to the terms of this agreement for services provided by Laura Richter, Ph.D., LMFT.

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Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Laura L. Richter, Ph.D. LMFT

\_\_\_\_\_  
Date

Initials: \_\_\_\_\_