INFORMED CONSENT AND FEE AGREEMENT
Services with EFT Clinic Counseling, LLD
736 S, 900 E. Suite 203-D, St. George, UT 84770
PH: 435-319-0086
Email: Support@DrRebeccaJorgensen.com

Therapist: Rebecca Jorgensen

The following information is provided to acquaint you with the procedures of this office and to better assist you in your efforts towards personal and relational growth.

_____I. **Your Rights as a Client**
(initials)

1. You have the right to ask questions about any procedures used during therapy.

2. You have the right to decide at any time not to receive therapy from Rebecca Jorgensen, PhD, LLC. If you wish, your assigned therapist will provide you with the names of other qualified professionals whose services you might prefer.

3. You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued.

_____II. **Confidentiality**
(initials)

1. Within certain limits, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your permission. At times therapy will involve the participation of more than one family member and/or significant persons. If we are doing Couple or Family Therapy, while our therapist's will attempt to follow your wishes, we do not guarantee confidentially among participants in the therapy.

2. There are certain situations in which your therapist is required by law to reveal information obtained during therapy to other persons or agencies without your permission. These situations include:
   a. If you threaten bodily harm or death to another person, your therapist is required by law to inform the intended victim and appropriate law enforcement agencies.
   b. If you threaten bodily harm or death to yourself, your therapist will inform the appropriate law enforcement agencies and others (such as spouse, friend, or an inpatient psychiatric institution) who could aid in prohibiting you from carrying out your threats.
   c. If you reveal information related to the abuse or neglect of a child, dependent adult, or elderly person, your therapist is required by law to report this to the appropriate authorities.

_____III. **Therapy Services and Fees for Intensive Work**
(initials)

1. The Intensive 3-day with an EFT master clinician is 10 - 12 hours, or the equivalent of approximately 15-20 weeks of therapy and costs $5,500.
   The 2-day intensive is 7 – 8 hours and costs $3,500.

2. Payment is secured with a non-refundable $2,750. deposit at the time of scheduling your intensive. The remaining payment is due at the completion of the intensive. If you intend to complete your payment with credit card payment please inform your therapist prior to the final session so proper arrangements can be made.

3. Email communication is for **non-emergencies** only. It may be used for appointment changes, referrals and non-clinical questions. Typical email response occurs within 48 hours during the work week, unless the office is close for a training event or some other reason. If you are canceling an appointment with less than 24 hours notice, please leave a message at the above number. Email correspondence with your therapist, Dr. Rebecca Jorgensen to this address will reach the support staff for your therapist: support@drrebeccajorgensen.com

_____IV. **Emotionally Focused Therapy – Couple Work**
(initials)

EFT is a structured approach to couples therapy formulated by Sue Johnson and Les Greenberg in the early 80's. The strategies and techniques of **EFT** are also used with families. A substantial body of research outlining the effectiveness of **EFT** now exists. This research demonstrates that couples significantly improve over the course of treatment and continue to get better at two year follow up. Please refer to the EFT website to get further information about the treatment model and present outcome research. www.eft.ca

The Goals of EFT are:

1. To expand and re-organize key emotional responses

2. To create a shift in interactional patterns with self and others

3. To foster the creation of a secure bond within and between

Consent

I understand that while being treated, my primary therapist at Rebecca Jorgensen, PhD, LLC will be Dr. Rebecca Jorgensen and that in case of emergency or problems during the week, I will contact her at the number she provides or use the emergency/crisis phone number 911. This release is valid for one year from the date of signature(s).

Client Name: _____

Client Signature:_____ Date:_____

Address: _____ Phone: _____

Client Name: _____

Client Signature:_____ Date:_____

Address: _____ Phone: _____

Therapist Signature:_____ Date:_____