ERJ COUNSELING

Elizabeth Reeder Johnson, MSW, LCSW
Child, Adolescent, Family & Couples Therapy

GROUP THERAPY INFORMED CONSENT FOR TREATMENT AND AGREEMENT FOR SEVICES

I _____authorize payment and consent to participate in the Group Therapy being facilitated by Elizabeth Reeder Johnson, MSW, LCSW. I understand that the group is being conducted via Telehealth. The group will last for 8 weeks, and I agree to pay $800 for the 8 sessions of group therapy. Payment by Vemno (all transactions are private) or Zelle needs to be submitted before the 1st group therapy session. Credit cards will be accepted, but Zelle and Venmo are preferred.

Payment Type (please circle one)	Credit Card # Or User Name (Email or Phone # with account)	Exp Date	3 Digit Security # on back of card	Billing Zip Code
Venmo/ Zelle/ Visa / MasterCard/ AmericanExpress/ Discover				

I understand that Elizabeth R. Johnson does not accept insurance for payment of services. If I request a receipt, I will be given one for group therapy appointments, which I can submit to my insurance company for reimbursement.

Notice of Confidentiality:
Elizabeth Reeder Johnson, MSW, LCSW will keep all information confidential, and no information will be released without written consent. In a group setting, this clinician encourages each group member to keep the confidentiality of the group, but that is hard to regulate outside the group setting. Individual respect for group confidentiality is strongly encouraged. The following are the specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to the client or to another person as indicated by suicidal or homicidal intentions, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I have had an opportunity to read this agreement, and I agree with all the provisions contained in this agreement and consent to group therapy.

Client's Name: _____

Client's Signature: _____ **Date:** _____

Parent/ Conservator's Signature if Client is a Minor _____ **Date:** _____