



Informed Consent

Part I: Your Rights as Client(s)

1. You have the right to ask questions about any procedures during therapy. All custodial parents have a right to information shared in the session of a minor child seen by me in therapy. Custodial parents should be aware that exercising this right may be detrimental to the therapeutic process, and may choose to allow confidentiality between the child and therapist. **I do not perform forensic evaluations.**
2. You have the right to decide not to receive therapeutic assistance from me. Upon request, I will provide you with the names of other qualified professionals you may choose to see.
3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued.
4. You have a right to review your records in the files in my presence in my office.
5. You have the right to **confidentiality**. I must have your permission to discuss your case outside of the office or consultation. Exceptions to this right are a) if you threaten to harm yourself or another person; b) if you reveal information about child or elder abuse, child or elder neglect; c) if I am court-ordered; d) if your therapy is court-ordered; and e) in third party payment arrangements.
6. You have the right to release any part of your record to any person or agency you designate. I will give you my opinion on whether releasing the information to that person or agency is harmful to you.
7. You have the right to be informed of possible risks and benefits of therapy. **Potential benefits** are improved ability to handle relationships (marital, family, and other interpersonal), greater understanding of family and personal goals and values, greater maturity and increased relational harmony. **Potential risks** include no improvement – some people think things are worse after therapy. Resolving unpleasant events and relationship patterns can arouse intense, uncomfortable feelings and may lead to relationship changes not originally intended.
8. One **risk** involves clients' use of medical insurance to pay for therapy. Harmful results of third party payment include: denial of insurability when applying for medical and disability insurance due to DSM-IV-TR diagnosis (mental diagnosis, which are usually required for reimbursements); company (mis)control of information when claims are processed; loss of confidentiality due to the large number of persons handling claims; loss of employment, and repercussions of diagnosis in situations which require truthfulness about "mental illness," including driver's license applications, concealed weapon permits, and job applications.



Mary Ann Crossno, CFLE, LMFT-A

Part II: The Therapeutic Process

Therapy will seek to meet goals established by all persons involved, usually revolving around a specific presenting problem. **I believe that problems grow from the way we relate to others.** I will ask you questions about your family background to gain a better understanding of your relationship patterns and coping skills.

I see my role as therapist as that of a guide, willing to search for all possible routes to help you go where you want to go. In some cases, I may have already taken a similar journey and my experience(s) may provide me with insights to share. If there are problems I am not qualified to help with I will refer you to a person qualified to help in that area. I see therapy as a team process in which we work together to achieve your desired goals. I will suggest techniques and tools designed to help you achieve those goals.

My qualifications are an MS in Family Therapy with a BS in Family Studies from Texas Woman's University. I am a Licensed Marriage and Family Therapist Associate, Texas license number 200909, practicing under the supervision of Dr. Glen Jennings, 940.898.2695.

Part III: Agreement and Fees

1. I agree to enter into therapy with Mary Ann Crossno. Session fees are \$110 for 90 minutes or \$75 for 60 minutes.
2. Payment is due at the end of each session, and no balance will be carried. Cash or check is accepted. No credit cards or third party payments are accepted.
3. I understand that I can leave therapy at any time and that I have no moral, legal, or financial obligation beyond each completed session.
4. A 24-hour notice is requested for cancellation of a scheduled session.
5. In case of emergency, I have been informed to call 911 or go the nearest emergency room.
6. I agree to discuss any complaint I have about my treatment with Mary Ann Crossno. If I am not satisfied, I will contact her supervisor, Dr. Glen Jennings at 940.898.2695.

Client (s): _____ Date: _____

_____ Date: _____

Therapist: _____ Date: _____