Allyn Rodriguez, Psy.D.

Licensed Psychologist PSY27459

3401 Glendale Blvd, 2nd Floor, Los Angeles, CA 90039 (504) 408-1762

Consent for Interpersonal Process Group

NAME: _____

ADDRESS: _____

CITY: _____ ZIP: _____

DATE OF BIRTH: _____

PRIMARY PHONE: _(____)_____ SECONDARY PHONE: (____)_____

E-MAIL: _____

EMERGENCY CONTACT NAME: _____
PHONE: _____

I am pleased to be working with you, and hope that this information will help you make an informed decision regarding my services. If you have any questions at any time, please to do not hesitate to ask.

Overview

Interpersonal Process Groups are an exciting, challenging, and powerful vehicle for your personal growth. In them, you can learn from your interactions with other group members about your and other's styles of relating (for example, patterns of interrupting and distorting communication). Groups can provide an immediate opportunity for you to experiment with new ways of being with others. Oftentimes, group can also provide a sense of closeness and belonging as it is an opportunity to connect with others and develop intimacy. The goal is that each member will learn to transfer new effective behaviors learned from the group to the rest of her/his life.

Membership

This interpersonal process group consists of 4-8 members and one psychologist. The group will be ongoing and members are asked to make an initial three (3) month commitment. This allows for adequate time to adjust to the group therapy environment, as well as the protection of the stability of the group for all participants.

Attendance

Members are expected to attend each session to help ensure that they maximize their own benefit from the experience and to foster a safe and stable environment within the group. When members decide to end their participation in the group, they are required to give four (4) weeks notice. This means that participants should plan to attend 4 sessions after giving their

notice to the group. Notice should be given in session and should be shared with all group members.

Therapeutic Orientation

The group is a suitable place to experiment with expressing oneself in new ways. In this group, members are encouraged to express feelings and thoughts openly. Group members can expect the following:

- The therapist will make observations about the group, the individuals in the group, and the interactions between group members. The therapist will encourage individuals, subgroups, and the group as a whole to explore their thoughts, feelings, and behaviors in the group.
- Each member will experience an increased awareness of opportunities for enacting new behaviors.
- Each member will have increased opportunities for interactive participation with other members.
- Each member is free to work at her/his own pace.
- The therapist will present various group therapy techniques and methods to the group members.

Feedback

There are two kinds of feedback that are very helpful:

1. The first is telling the other person what you experience when she/he does a certain thing or acts in a certain way. Examples are: "When you raise your voice like that, I want nothing to do with you...or I feel frustrated" etc. So I encourage you to give feedback on how others affect you emotionally.
2. The second kind of feedback is simply reflecting back to another person what you observe, such as, "Right now, I see you clenching your fist," or "I notice how soft your voice becomes when you talk about her." Advice, suggestions, or interpretations are generally unhelpful – we strongly encourage you to make observations.

Relationships Outside of the Group

Personal relationships between members outside of group is discouraged. If group members encounter each other outside of sessions, the group must be informed.

Privacy & Confidentiality

Confidentiality means that it is necessary for me to obtain your written consent even to acknowledge to someone outside the group that you are a member of the group.
HIPAA allows these therapists to use or disclose confidential information (including but not limited to personal health information (PHI)) for purposes of treatment, payment, and health care operations with informed written consent, signified by signing this document. In other words, for purposes other than treatment, payment, and healthcare operations, I can only release information about you if you sign a written Authorization form that meets certain legal requirements imposed by state law and/or HIPAA.

However, there are some additional important legal and ethical exceptions to complete confidentiality that you should be aware of. There are some situations in which we are permitted or required to disclose information about you without either your consent or Authorization. In all

cases we will try to disclose only the information that is minimally necessary to meet the needs of the situation.

. 1) **Serious Threat to Health or Safety**: If I have reason to suspect that you may seriously harm either yourself or another person(s), and I judge that there is a clear and substantial risk of imminent danger of that happening, I may breach confidentiality to the extent necessary to protect you or others. This can include seeking hospitalization for you or contacting family members or others who can help to provide protection. This could also include notifying potential victim(s) or contacting the police.

. 2) **Child Abuse**: If I have reasonable cause to believe that a child with whom I have had contact has been abused, I may be required to report the abuse. Additionally, if I have reasonable cause to believe that an adult with whom I have had contact has abused a child, I may be required to report the abuse. In any child abuse investigation, I may be compelled to turn over PHI. Regardless of whether I am required to disclose PHI or to release documents, I also have an ethical obligation to prevent harm to my clients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI to prevent harm.

. 3) **Mentally Ill or Developmentally Disabled Adults**: If I have reasonable cause to believe that a mentally ill or developmentally disabled adult has been abused, I may be required to report the abuse. Additionally, if I have reasonable cause to believe that any person with whom I have had contact has abused a mentally ill or developmentally disabled adult, I may be required to report the abuse. Regardless of whether I am required to disclose PHI or to release documents, I have an ethical obligation to prevent harm to my clients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI to prevent harm.

. 4) **Other Abuse**: I may have an ethical obligation to disclose your PHI to prevent harm to you or others.

. 5) **Medical**: I may disclose information that would facilitate treatment in a medical emergency.

. 6) **Court Proceedings**: If you are involved in or anticipate becoming involved in any legal or court- related proceedings, please notify me as soon as possible. It is important for me to understand how, if at all, your involvement in these proceedings might affect our work together. Your PHI may become subject to disclosure if any of the following occur: a) if you become involved in a lawsuit and your mental or emotional condition is an element of your claim, b) if a court orders your PHI to be released, or c) if a court orders you to undergo a mental evaluation. I will make every effort to discuss the release of your PHI beforehand. If our treatment involves more that one family member, please be aware that my treatment record may contain information about more that one person in the family.

. 7) **Government Health Oversight**: If a government agency or the Oregon State Board of Psychologist Examiners is requesting information for health oversight activities, I may be required to provide it to them.

. 8) **Legal Defense**: If a client files a complaint or a lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

. 9) **Worker's Compensation Claim**: If you file a Worker's Compensation Claim, this constitutes authorization for me to release your relevant mental health records to involved parties and officials. This would include past history of complaints or treatment of a condition similar to that involved in the worker's compensation claim.

. 10) **Insurance or Fee Collection**: As discussed elsewhere in this Agreement, I will likely have to

release information regarding your diagnosis or treatment in order to complete your claim. Most insurance companies also retain the right to conduct periodic audit reviews of records. Similarly, I may pursue collection of overdue fees without further Authorization.

. 11) **Colleagues On-Call**: When I am away and not taking calls or receiving messages, I will have a professional colleague on-call for me. Since this person changes from time to time, if you have an emergency that requires him/her to either talk with you by phone or meet with you in an office visit, we will not complete a separate authorization. This person will adhere to the same standards of privacy and confidentiality described in this document.

. 12) **Consultation**: At times I may find it helpful, on your behalf, to consult with other mental health and health professionals, who are not involved in your case, to insure that you receive the best treatment possible. During a consultation, I make every effort to avoid revealing your identity. The other professionals with whom I consult are also legally bound to keep the information confidential. I will assume that this is acceptable to you unless you notify me in writing. I will not tell you about these consultations unless I feel that it is important to our work together. If significant treatment decisions are affected by a consultation, it will be recorded in your clinical record.

Confidentiality Issues Specific to Group Therapy

Group members and group therapists will not discuss the group, including its membership and content discussed, with outsiders in any way that might jeopardize any member's confidentiality or privacy, except:

- In instances of imminent danger to anyone, at which point the therapists will take action to ensure safety.
- If the therapists are required by law or HIPAA regulations to disclose information about sessions.
- In your individual therapy sessions, if applicable, where rules of confidentiality also apply.

Recommendations

In order to get the most out of the group experience, it is recommended that members:

- Arrive five minutes early to the meeting room to get settled.
- Miss no sessions unless unavoidable (medical or family emergencies)
- Become aware of counterproductive, fixed, stuck patterns
- Seek and take opportunities to engage in new behaviors

Fees

Each group session costs $70.00. In some cases a reduced fee is available, which should be discussed directly with me. Payment for the month is due at the first session of each month. Payments by check should be made out to Allyn Rodriguez, PsyD. You will be charged for each session you commit to whether you attend or not; insurance will not cover the fee for missed sessions. You are still responsible for the session fee even if you call to cancel (except in the case of medical or family emergencies).

Emergencies

To contact me, please call **(504) 408-1762.** I will return your call as soon as possible, but may not be able to do so until the next business day. Because I often retrieve messages remotely, it

is important that you leave your phone number so I can return your message promptly. **If you are in crisis, especially if you think you may harm yourself or someone else, go to the nearest hospital emergency room or call 911.** You can also call The LA County Mental Health Crisis line at 1-800-854-7771, where a crisis worker will be able to assess your situation and recommend the best way to help.

Please feel free to discuss any questions or concerns you may have with this consent form. You are not obligated to sign this form, and have the right to not do so. Your signature acknowledges that you have read, understood, and agree to abide to the terms of this document.

I have received a copy of and have read the Consent for Interpersonal Process Group with Allyn Rodriguez, PsyD. I have received satisfactory answers to any questions I had pertaining to its contents. I accept the terms set forth in this Agreement.

_____ _____

Signature of Client Date