|  |  |
| --- | --- |
| Client’s Name:      | DOB:       |
| Address:      |
| Home#:      | Cell#:      | Work#:       |
| Email:      |
| Emergency Contact:      | Allergies:       |
| Primary Care Physician:       | Specialists:       |
| Reason for Referral: | Referred By:       |
| **My signature indicates that I have read, understand and agree to the consents, policies and procedures outlined herein.** **Signature:**      |
| Consent for Treatment | **Initial:** |
| Equine Assisted Psychotherapy & Equine Assisted Growth & Learning Consent | **Initial:** |
| Custody Status of Minor Child Confirmation | **Initial:** |
| EMDR & Hypnosis Consent | **Initial:** |
| Payment and Attendance Policy **NO INSURANCE ACCEPTED** | **Initial:****NO INSURANCE ACCEPTED**  |
| Notice of Privacy Procedures | **Initial:** |
| Electronic Communication Consent | **Initial:** |
| Video Consent | **Initial:** |
| Consultation & Supervision  | **Initial:** |

**Consent for Treatment**

I give permission for      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to participate in psychotherapy with Laura McLaughlin, LMFT, LMHC which may include equine assisted psychotherapy, eye-movement desensitization and reprocessing, hypnosis, cognitive behavioral therapy or other professionally recognized models of therapy. I understand the benefits and risks of treatment and the inherent risks associated with exposure to horses in the context of equine assisted psychotherapy or equine assisted learning and have read the Massachusetts Statutes below. I understand that Laura McLaughlin is a licensed mental health clinician and maintains EAGALA model certification in EAP & EAL and will take every precaution to provide a safe environment. I also understand that during the use of the EAGALA model she will be accompanied by an Equine Specialist.

Please be advised that horses are dangerous and I do not insure against any possible risk of injury or loss connected with any equine activity on or at 6 Cambridge Street Chelmsford, MA 01824. By signing this waiver I declare that I will assume all responsibilities, for myself or a minor in my guardianship or care, safety and wellbeing.

I understand that therapy may include discussing unpleasant aspects of my life; that I may experience feelings of anxiety, sadness, guilt, anger, frustration, loneliness and helplessness. Distressing and unresolved memories may surface through counseling. Subsequent to treatment sessions, the processing of incidents and material may continue and dreams, memories, flashbacks, and feelings may surface. Memory is imperfect and research has shown that there is no guarantee that all information recovered during therapy, unless it can be corroborated is factually accurate. On the other hand, information which is so revealed may in fact be accurate. The benefits may be improved relationships, solutions to specific problems and significant reductions in feelings of distress.

I agree to treatment and understand that I can withdraw my consent at any time by notifying my therapist that I no longer wish to participate. I authorize information to be released to my designated private physician. I also understand that insurance will not be billed for these services and it is the responsibility of the client to pay all professional fees at the time of service delivery.

I hereby release and hold harmless, Laura McLaughlin, and all affiliated property owners and equine specialists from all liability. Please understand that by signing this document you will be waiving all valuable legal rights.

**Massachusetts Equine Activity Statutes**

**Chapter 128:  Section 2D.**

**Liability of equine professionals and equine activity sponsors.**

(a) For the purposes of this section, the following words shall have the following meanings:

**“Engage in an equine activity” -** Riding, training, assisting in veterinary treatment of, driving, or being a passenger upon an equine, whether mounted or unmounted, visiting or touring or utilizing an equine facility as part of an organized event or activity, or assisting a participant or show management. The term “engage in an equine activity”

shall not include being a spectator at an equine activity, except in cases where the spectator places himself in an unauthorized area or in immediate proximity to the equine activity. **“Equine” –** A horse, pony, mule, or donkey.

**“Equine activity” –**

(1) equine shows, fairs, competitions, performances, or parades that involve any or all breeds of equines and any of the equine disciplines, including, but not limited to, dressage, hunter and jumper horse shows, grand prix jumping, three-day events, combined training, rodeos, riding, driving, pulling, cutting, polo, steeplechasing, English and western performance riding, endurance trail riding, gymkhana games, and hunting;

(2) equine training or teaching activities or both;

(3) boarding equines; including normal daily care thereof;

(4) riding, inspecting, or evaluating by a purchaser or an agent an equine belonging to another, whether or not the owner has received some monetary consideration or other thing of value for the use of the equine or is permitting a prospective purchaser of the equine to ride, inspect, or evaluate the equine;

(5) rides, trips, hunts or other equine activities of any type however informal or impromptu that are sponsored by an equine activity sponsor;

(6) placing or replacing horseshoes or hoof trimming on an equine; and

(7) providing or assisting in veterinary treatment.

**“Equine activity sponsor” -** An individual, group, club, partnership, or corporation, whether or not the sponsor is operating for profit or nonprofit, which sponsors, organizes, or provides the facilities for, an equine activity, including but not limited to: pony clubs, 4-H clubs, hunt clubs, riding clubs, school and college-sponsored classes, programs and activities, therapeutic riding programs, stable and farm owners and operators, instructors, and promoters of equine facilities, including but not limited to farms, stables, clubhouses, pony ride strings, fairs, and arenas at which the activity is held.

**“Equine professional” -** A person engaged for compensation:

(1) in instructing a participant or renting to a participant an equine for the purpose of riding, driving or being a passenger upon the equine;

(2) in renting equipment or tack to a participant;

(3) to provide daily care of horses boarded at an equine facility; or

(4) to train an equine.

**“Inherent risks of equine activities” –** Dangers or conditions which are an integral part of equine activities, including but not limited to:

(1) The propensity of equines to behave in ways that may result in injury, harm, or death to persons on or around them;

(2) the unpredictability of an equine’s reaction to such things as sounds, sudden movement, and unfamiliar objects, persons, or other animals;

(3) certain hazards such as surface and subsurface conditions;

(4) collisions with other equines or objects;

(5) the potential of a participant to act in a negligent manner that may contribute to injury to the participant or others, such as failing to maintain control over the animal or not acting within his ability.

**“Participant” -** Any person, whether amateur or professional, who engages in an equine activity, whether or not a fee is paid to participate in such equine activity.

(b) Except as provided in subsection (c), an equine activity sponsor, an equine professional, or any other person, which shall include a corporation or partnership, shall not be liable for an injury to or the death of a participant resulting from the inherent risks of equine activities and, except as provided in said subsection (c), no participant nor participant’s representative shall make any claim against, maintain an action against, or recover from an equine activity sponsor, an equine professional, or any other person for injury, loss, damage, or death of the participant resulting from any of the inherent risks of equine activities.

(c) This section shall not apply to the racing meetings as defined by section one of chapter one hundred and twenty-eight A. Nothing in subsection (b) shall prevent or limit the liability of an equine activity sponsor, an equine professional, or any other person if the equine activity sponsor, equine professional, or person:

(1)

(i) provided the equipment or tack, and knew or should have known that the equipment or tack was faulty, and such equipment or tack was faulty to the extent that it did cause the injury; or

(ii) provided the equine and failed to make reasonable and prudent efforts to determinethe ability of the participant to engage safely in the equine activity, and determine the ability of the participant to safely manage the particular equine based on the participant’s representations of his ability;

(2) owns, leases, rents, has authorized use of, or is otherwise in lawful possession and control of the land, or facilities upon which the participant sustained injuries because of a dangerous latent condition which was known to the equine activity sponsor, equine professional, or person and for which warning signs, pursuant to subsection (d), have not been conspicuously posted;

(3) commits an act of omission that constitutes willful or wanton disregard for the safety of the participant, and that act of omission caused the injury; or

(4) intentionally injures the participant.

(d)

(1) Every equine professional shall post and maintain signs which contain the warning notice specified in paragraph (2). Such signs shall be placed in a clearly visible location in the proximity of the equine activity. The warning notice specified in said paragraph (2) shall appear on the sign in black letters, with each letter to be a minimum of one inch in height. Every written contract entered into by an equine professional for the providing of professional services, instruction, or the rental of equipment or tack or an equine to a participant, whether or not the contract involves equine activities on or off the location or site of the equine professional’s business, shall contain in clearly readable print the warning notice specified in said paragraph (2).

(2) The signs and contracts described in paragraph (1) shall contain the following notice:

**Under Massachusetts law, an equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities, pursuant to section 2D of chapter 128 of the General Laws.**

**Custody Status of Minor Child**

I agree to provide ongoing and accurate information regarding the custody status of my minor child. In compliance with state and federal laws, participation in therapy requires consent from all responsible parties.

|  |
| --- |
| Please indicate the names, addresses and telephone numbers of all responsible parties. Please indicate current visitation or living schedules. |
|  |
| Please circle the custody status of the minor child. |
| **Temporary Custody:** "De facto" (means "in fact") custody refers to who actually has custody of the child at this time. This can be different from "court ordered custody". Temporary custody will be based on the "best interests" of the child standard. It is not an "initial" award of custody. Instead it is temporary custody while you wait for the court to hold a hearing. **Sole Custody:** Sole custody is made up of: legal custody and physical custody. A person with legal custody has the right to make long range plans and decisions for the education, religious training, discipline, non-emergency medical care and other matters of major significance concerning the child's welfare. A person with physical custody has the child living primarily with them and they have the right to make decisions as to the child's everyday needs. Sole Custody is when both legal and physical custody are given to one parent. The child has only one primary residence.**Split Custody:** Split custody is easiest to describe in a situation where there are two children and each parent obtains full physical custody over one child. Some of the considerations that may bring about this result are age of the children and child preference.**Joint Custody**: Joint Custody is actually broken down into three categories: Joint Legal, Shared Physical, and Combination. •Joint Legal custody is where the parents share care and control of the upbringing of the child, but the child has only one primary residence. • In Shared Physical Custody the child has two residences, spending at least 35% of their time with the other parent. • Additionally, you can make your own special joint custody agreement that is any combination of Shared Physical and Joint Legal Custody. One example of this is when there is one residence for the child and the parents live with the child there on a rotating basis. |

**Payment and Attendance Policy**

Laura McLaughlin, LMFT, LMHC is in private practice and **insurance is not accepted at this site.**

**Initial Equine Assisted Psychotherapy Session: $250.00 50 min**

**Follow Up Equine Assisted Psychotherapy Session: $125.00 50 min**

**Standard Non Equine Session $125.00 50 min**

**Supervision $125.00 50 min**

**Letter Writing / Collateral Contact $ 25.00 ¼ hour**

**Telephone / Telecounseling $ 50.00 ½ hour (existing MA clients only)**

All charges are expected at the time services are rendered. All professional services rendered are charged to you unless prior arrangements with us have been made. Payments include the full cost of the session which may include no show or late cancellation appointment charges. During inclement weather or equine related emergencies late cancellations may be made to ensure safety. These unavoidable and therefore charges will not be incurred.

If you are unable to keep your scheduled appointment, kindly cancel 24 hours prior to that time. Without a 24 hour cancellation notice, you will be charged for the time reserved. This charge is not covered by any private insurance. You may also risk your previously arranged appointment time. If you have an overdue balance please remit your balance within ten days. If you have a scheduled appointment and have not yet paid your balance please contact your clinician to reschedule, cancel or coordinate payment. Overdue payments will be expected within ten days or prior to your next scheduled appointment, whichever may occur first. Any balance that has been overdue for 60 days will be sent to collections and clients will no longer be eligible for services. We reserve the right to suspend treatment until any overdue balance is paid. I accept the financial responsibility for any charges not covered by insurance. I have read this policy and I agree to the terms of the payment and appointment policy.

**Notice of Privacy Procedures**

Laura McLaughlin, LMFT, LMHC is dedicated to maintaining the privacy of your personal health information and is required by law to do this. I understand that this equine facility has a private residence on the premises and may be subject to unexpected occurrences and activities on the property or nearby. Attempts will be made to eliminate any foreseen interruptions and to maximize and protect client privacy. Any accompanying equine specialists will be held to the same standards. Privacy laws are complicated, but this notice is a shorter version of the full, legally required NPP which you may refer to at: hppt://www.hhs.gov.gov/ocr/privacy/hippaa/understanding/summary.pdf

I will use the information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services or for some other business activities which are called, in the law, health care operations. After you have read this NPP I will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, I cannot treat you.

If I or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization to allow this.

Of course I will keep your health information private but there are some times when the laws require us to use or share it such as:

* When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.
* Some lawsuits and legal or court proceedings.
* If a law enforcement official requires us to do so.
* For Workers Compensation and similar benefit programs.
* There are some other situations like these but which don’t happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information:

* You can ask the Provider to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask the Provider to call you at home and not at work to schedule or cancel an appointment.
* You have the right to ask the Provider to limit what is told to certain individuals involved in your care or the payment for your care, such as family members and friends. While the Provider does not have to agree to your request, if there is agreement, it will be honored except if it is against the law, in an emergency, or when the information is necessary to treat you.
* You have the right to look at the health information such as your medical and billing records. You can even get a copy of these records but there may be a charge to you.
* If you believe the information in your records is incorrect or incomplete, you can ask the Provider to make some kinds of changes (called amending) to your health information. You have to make this request in writing and share the reasons you want to make the changes.
* You have the right to a copy of this notice. If there is a change this NPP it will be posted on above website and in the barn.
* You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Provider and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way. If you have any questions regarding this notice or my health information privacy policies, please contact me. Laura McLaughlin, LMFT, LMHC, P.O. Box 474 Chelmsford, MA (978) 328-7346. The effective date of this notice is October 6, 2014

**Electronic Communications (EC)**

**In a medical emergency, do not use email. Call 911.**

1. Risk of Using Electronic Communications (Email or Text)

The Provider will provide clients the opportunity to communicate by e-mail. Transmitting patient information by EC, however, has a number of risks that patients should consider before using EC. These include, but are not limited to, the following risks:

* EC can be circulated, forwarded, and stored in numerous paper and electronic files.
* EC can be immediately broadcast worldwide and be received by many intended and unintended recipients.
* EC senders can easily misaddress an e-mail
* EC is easier to falsify than handwritten or signed documents.
* Backup copies of EC may exist even after the sender or the recipient has deleted his or her copy.
* Employers and on-line services have a right to archive and inspect EC transmitted through their systems.
* EC can be intercepted, altered, forwarded, or used without authorization or detection.
* EC can be used to introduce viruses into computer systems.
* EC can be used as evidence in court.

2. Conditions for the Use Electronic Communications

Reasonable means will be given to protect the security and confidentiality of EC information both sent and received. However, because of the risks outlined above, the Provider cannot guarantee the security and confidentiality of EC communication, and I will not be liable for improper disclosure of confidential information that is not caused by my intentional misconduct. Thus, you must consent to the use of EC for patient information. Consent to the use of EC:

* EC may be forwarded to ES & EAP staff and agent necessary for scheduling. However, EC will not be forwarded to independent third parties without the patient’s prior written consent, except as authorized or required by law.
* Although the Provider will endeavor to read and respond promptly to EC from a client, it is not guaranteed that any particular EC will be read and responded to within any particular period of time thus the patient shall not use EC for medical emergencies or other time sensitive matters.
* If the client’s EC requires or invites a response, and the client has not received a response within a reasonable time period, it is the client’s responsibility to follow up to determine whether the intended recipient will respond.
* The client should not use EC for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases AIDS/ HIV, mental health, developmental disability, or substance abuse.
* The client is responsible for providing any type of information that the client does not want to be sent by EC in addition to sensitive material previously described.
* The client is responsible for protecting his/her password or other means of access to EC. The Provider is not liable for breaches of confidentiality caused by the patient or any third party.
* The Provider will not engage in EC communication that is unlawful, such as unlawfully practicing across state lines.
* It is the client’s responsibility to follow up and / or schedule an appointment if warranted.
* The client must be 18 years or older or an emancipated or self-sufficient minor before an EC can be sent about the client.

3. Instructions

To communicate by or EC, the client shall:

* Inform Provider of changes in his / her EC.
* Put the client’s name in the body of the EC.
* Include the category of the communication in the EC subject line, for routing purposes.
* Review the EC to make sure it is clear and that all relevant information is provided before sending to me including a phone number.
* Take precautions to preserve the confidentiality of your EC.
* Withdraw consent to use EC only by written communication to Provider.

4. Alternative Forms of Communication

I understand that I may also communicate with the Provider via telephone or during a scheduled appointment and that e-mail and text is not a substitute for the care that may be provided during an office visit. Appointments should be made to discuss any new issues as well as any sensitive medical information.

5. Types of EC (Email or Text Transmissions) that Client Agrees to Send and/ or Receive

The types of information that can be communicated via EC include referrals, appointment scheduling requests, billing and client education. If you are not sure if the issue you wish to discuss should be included in an EC, you should call me to schedule an appointment.

6. Security Measures used by the Provider

As stated above, communicating via EC does come with privacy risk as stated above. The Provider cannot guarantee total confidentiality, reasonable safeguards to protect your health care information as required by law. The security measures taken include password protected screen savers, policies and procedures, and staff training requirements.

7. Termination of the EC Relationship

The provider reserves the right and discretion to immediately terminate the EC relationship if the terms and conditions set forth above or otherwise are breached, determined to be unacceptable or no longer wishes to utilize the e-mail to communicate with clients.

8. Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the inherent risks of counseling, equine activities and the associated risks of electronic communication, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that may impose to communicate with clients by EC.

 **EMDRIA Definition of EMDR –Eye Movement Desensitization & Reprocessing**

*Date of adoption 5/26/03, 10/18/03; Revised 10/25/09, 06/23/11, 12/07/11, 2/25/12*

**1.0A. Purpose of Definition** – This definition serves as the foundation for policy development and implementation of EMDRIA’s programs in the service of its mission. This definition is intended to support consistency in EMDR training, standards, credentialing, continuing education, and clinical application, while fostering the further evolution of EMDR through a judicious balance of innovation and research. This definition also provides a clear and common frame of reference for EMDR clinicians, consumers, researchers, the media and the general public.

**1.0B. Definition** - EMDR is an evidence-based psychotherapy for Posttraumatic Stress Disorder (PTSD). In addition, successful outcomes are well-documented in the literature for EMDR treatment of other psychiatric disorders, mental health problems, and somatic symptoms. The model on which EMDR is based, Adaptive Information Processing (AIP), posits that much of psychopathology is due to the maladaptive encoding of and/or incomplete processing of traumatic or disturbing adverse life experiences. This impairs the client’s ability to integrate these experiences in an adaptive manner. The eight-phase, three-pronged process of EMDR facilitates the resumption of normal information processing and integration. This treatment approach, which targets past experience, current triggers, and future potential challenges, results in the alleviation of presenting symptoms, a decrease or elimination of distress from the disturbing memory, improved view of the self, relief from bodily disturbance, and resolution of present and future anticipated triggers.

**BI. Foundational Sources and Principles for Evolution** - Shapiro’s (2001) Adaptive Information Processing model, guides clinical practice, explains EMDR’s effects, and provides a common platform for theoretical discussion. The AIP model provides the framework through which the eight phases and three prongs (past, present, and future) of EMDR are understood and implemented. The evolution and elucidation of both mechanisms and models are ongoing through research and theory development.

**BII. Aim of EMDR** - In the broadest sense, EMDR is an integrative psychotherapy approach intended to treat psychological disorders, to alleviate human suffering and to assist individuals to fulfill their potential for development, while minimizing risks of harm in its application. For the client, EMDR treatment aims to achieve comprehensive treatment safely, effectively and efficiently, while maintaining client stability.

**BIII. Framework** - Through EMDR, resolution of traumatic and disturbing adverse life experiences is accomplished with a unique standardized set of procedures and clinical protocols which incorporates dual focus of attention and alternating bilateral visual, auditory and/or tactile stimulation. This process activates the components of the memory of disturbing life events and facilitates the resumption of adaptive information processing and integration. The following are some of the AIP tenets which guide the application of EMDR, i.e., planning treatment and achieving outcomes:

**BIIIa.** Adverse life experiences can generate effects similar to those of traumatic events recognized by the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2000) for the diagnosis of Posttraumatic Stress Disorder (PTSD) and trigger or exacerbate a wide range of mental, emotional, somatic, and behavioral disorders. Under optimal conditions, new experiences tend to be assimilated by an information processing system that facilitates their linkage with already existing memory networks associated with similarly categorized experiences. The linkage of these memory networks tends to create a knowledge base regarding such phenomena as perceptions, attitudes, emotions, sensations and action tendencies.

**BIIIb.** Traumatic events and/or disturbing adverse life experiences can be encoded maladaptively in memory resulting in inadequate or impaired linkage with memory networks containing more adaptive information. Pathology is thought to result when adaptive information processing is impaired by these experiences which are inadequately processed. Information is maladaptively encoded and linked dysfunctionally within emotional, cognitive, somatosensory, and temporal systems. Memories thereby become susceptible to dysfunctional recall with respect to time, place, and context and may be experienced in fragmented form. Accordingly, new information, positive experiences and affects are unable to

functionally connect with the disturbing memory. This impairment in linkage and the resultant inadequate integration contribute to a continuation of symptoms.

**BIV. EMDR Psychotherapy Guidelines:** EMDR procedures facilitate the effective reprocessing of traumatic events or adverse life experiences and associated beliefs, to an adaptive resolution. Specific procedural steps are used to access and reprocess information which incorporates alternating bilateral visual, auditory, or tactile stimulation. These well-defined treatment procedures and protocols facilitate information reprocessing. EMDR utilizes an 8-phase, 3-pronged, approach to treatment that optimizes sufficient client stabilization before, during, and after the reprocessing of distressing and traumatic memories and associated stimuli. The intent of the EMDR approach to psychotherapy is to facilitate the client’s innate ability to heal. Therefore, during memory reprocessing, therapist intervention is kept to the minimum necessary for the continuity of information reprocessing.

**BIVa.** Based on available relevant research, treatment fidelity to the 8 phases (Shapiro, 2001) produces the best results. However, in certain situations and for some populations, the following procedures may be implemented in more than one way as long as the broad goals of each phase are achieved.

**BIVai.** In the **Client History Phase (Phase 1),** the clinician begins the process of treatment planning using the concept of incomplete processing and integration of memories of adverse life experiences. The clinician identifies as complete a clinical picture as is prudent before offering EMDR reprocessing. The clinician determines the suitability of EMDR therapy for the client and for the presenting problem and determines whether the timing is appropriate. Based on the presenting issue, the clinician explores targets for future EMDR reprocessing from negative events in the client’s life. The clinician prepares a treatment plan with attention to past and present experiences, and future clinical issues. It is also important to identify positive or adaptive aspects of the client’s personality and life experience. The clinician may need to postpone completing a detailed trauma history when working with a client with a complex trauma history until the client has developed adequate affect regulation skills and resources to remain stable. The clinician may need to address any secondary gain issues that might prevent positive treatment effects.

**BIVaii.** In the **Preparation Phase (Phase 2**), the clinician discusses the therapeutic framework of EMDR with the client and gives sufficient information so the client can give informed consent. The therapist prepares the client for EMDR reprocessing by establishing a relationship sufficient to give the client a sense of safety and foster the client’s ability to tell the therapist what s/he is experiencing throughout the reprocessing. The client develops mastery of skills in self-soothing and in affect regulation as appropriate to facilitate dual awareness during the reprocessing sessions and to maintain stability between sessions. Some clients may require a lengthy preparation phase for adequate stabilization and development of adaptive resources prior to dealing directly with the disturbing memories. It may be important, especially for those clients with complex trauma, to enhance the ability of the individual to experience positive affect through promoting the development and expansion of positive and adaptive memory networks, thus expanding the window of affect tolerance, and stimulating the development of the capacity for relationship.

**BIVaiii.** In the **Assessment Phase (Phase 3)** the clinician identifies the components of the target/issue and establishes a baseline response. Once the memory or issue (with a specific representative experience) has been identified, the clinician asks the client to select the image or other sensory experience that best represents it. The clinician then asks for a negative belief that expresses the client’s currently held maladaptive self-assessment that is related to the experience, a positive belief to begin to stimulate a connection between the experience as it is currently held with the adaptive memory network(s) and the validity of the positive belief, utilizing the 7 point Validity of Cognition (VOC) scale. Finally, the clinician asks the client to name the emotions evoked when pairing the image or other sensory experience and the negative belief, to rate the level of disturbance utilizing the 0 to 10 Subjective Units of Disturbance (SUD) scale and to identify the location of the physical sensations in the body that are stimulated when concentrating on the experience.

**BIVaiv.** During the **Desensitization Phase (Phase 4)** the memory is activated and the clinician asks the client to notice his/her experiences while the clinician provides alternating bilateral stimulation. The client then reports these observations. These may include new insights, associations, information, and emotional, sensory, somatic or behavioral shifts. The clinician uses specific procedures and interweaves if processing is blocked. The desensitization process continues until the SUD level is reduced to 0 (or an ecologically valid rating). It is important during this phase to assist the individual in maintaining an appropriate level of arousal and affect tolerance.

**BIVav.** In the **Installation Phase (Phase 5**), the therapist first asks the client to check for a potential new positive belief related to the target memory. The client selects a new belief or the previously established positive cognition. The clinician asks him/her to hold this in mind, along with the target memory, and to rate the selected positive belief on the VOC scale of 1 to 7. The therapist then continues alternating bilateral stimulation until the client's rating of the positive belief reaches the level of 7 (or an ecologically valid rating) on the VOC Scale.

**BIVavi.** In the **Body Scan Phase (Phase 6),** the therapist asks the client to hold in mind both the target event and the positive belief and to mentally scan the body. The therapist asks the client to identify any positive or negative bodily sensations. The therapist continues bilateral stimulation when these bodily sensations are present until the client reports only neutral or positive sensations.

**BIVavii.** The **Closure Phase (Phase 7)** occurs at the end of any session in which unprocessed, disturbing material has been activated whether the target has been fully reprocessed or not. The therapist may use a variety of techniques to orient the client fully to the present and facilitate client stability at the completion of the session and between sessions. The therapist informs the client that processing may continue after the session, provides instructions for maintaining stability, and asks the client to observe and log significant observations or new symptoms.

**BIVaviii.** In the **Reevaluation Phase (Phase 8),** the clinician, utilizing the EMDR standard three-pronged protocol, assesses the effects of previous reprocessing of targets looking for and targeting residual disturbance, new material which may have emerged, current triggers, anticipated future challenges, and systemic issues. If any residual or new targets are present, these are targeted and Phases 3-8 are repeated.

**BV. Innovation, Flexibility and Clinical Judgment as Applied to Particular Clients or Special Populations**

**BVa.** To achieve comprehensive treatment effects a three-pronged basic treatment protocol is generally used so that past events are reprocessed, present triggers desensitized, and future adaptive outcomes explored for related challenges. The timing of addressing all three prongs is determined by client stability, readiness and situation. There may be situations where the order may be altered or prongs may be omitted, based on the clinical picture and the clinician’s judgment.

**BVb.** As psychotherapy, EMDR unfolds according to the needs, resources, diagnosis, and development of the individual client in the context of the therapeutic relationship. Therefore, the clinician, using clinical judgment, emphasizes elements differently depending on the unique needs of the particular client or the special population. EMDR treatment is not completed in any particular number of sessions. It is central to EMDR that positive results from its application derive from the interaction among the clinician, the therapeutic approach, and the client.

American Psychiatric Association (2000), *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition*, Washington DC.

Shapiro, F. (2001). *Eye Movement Desensitization and Reprocessing, 2nd edition,* N.Y.: The Guilford Press

**Eye Movement Desensitization and Reprocessing (EMDR)** methodology is a form of adaptive information processing when may help the brain unblock maladaptive material. I have been advised and understand that EMDR is a treatment approach that has been widely validated by research on PTSD. Some studies indicate that EMDR is also effective in reducing anxiety and other symptoms.

I have also been specifically advised of the following:

1. Distressing unresolved memories may be surface through the use of the EMDR procedure.
2. Some clients experience reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including but not limited to the high level of emotional or physical sensations, disorientation, fear or nausea.
3. Subsequent to the treatment session, the processing of incidents/material may continue and dreams, memories, flashbacks, feelings may surface.
4. Memory is imperfect and research has shown that there is no guarantee that all information recovered during therapy, unless it can be corroborated is factually accurate. On the other hand, information which is so revealed may in fact be accurate. Similar to hypnosis, memories recalled via EMDR may be considered by courts to be invalid for use in any future legal actions.

My clinician has explained to me the reasons why the use of EMDR is recommended in my therapy or for my child and that there are other options available to me should I decide not to use EMDR and not to give my informed consent. The clinician has provided me with an explanation about the nature of EMDR and my questions about EMDR have been answered.

Before commencing EMDR treatment, I have considered all of the above and I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate to having EMDR treatment and by my signature below I hereby consent to participating in EMDR treatment. I understand that I may stop treatment at any time before or during any EMDR session and that more than one EMDR session is usually necessary in the treatment.

My signature on this acknowledgment and consent is free from pressure or intelligence from any person or entity and I agree to hold harmless my EMDR clinician for any unpleasant or unexpected effects which may arise from my experience or my child’s experience with EMDR.

**Informed Consent to Video Record**

My signature confirms that conditions of my consent to utilize a video record have been explained to me,

and I understand the following:

* I am not required to consent to the use of video and I am under no obligation to have this session recorded.
* I can withdraw my permission at any time during or after the session. My access to counseling
* services will not be affected by my decision not to consent to a video record.
* I have the right to review this recording with my counselor during a counseling session.
* This record will not be shared without your specific written consent outlining the circumstances.
* Only my first name will be used or my name will not be mentioned; the contents of the recording will
* remain confidential.
* The video record will become part of your permanent record or destroyed upon your request.
* This consent expires one year from the date of my signature. I may revoke this
* video consent at any time.
* A copy of this consent form will be kept in my permanent medical record along with any amendments.

**3rd Party Supervision Agreement (Pre-Licensure Only)**

The following document is a guideline of expectations for both supervisee and supervisors entering into the agreement. Both supervisee and supervisors have the ability to amend the following stipulations of this contract when all parties agree it is necessary. This document is meant to create guidelines and boundaries for the supervision of supervisee to work towards licensure and/or delegate supervision responsibilities between parties. By consenting to this supervision agreement all parties agree to adhere to expectations listed below. I understand that place of employment agrees to and has been informed that I am receiving off-site supervision from Laura McLaughlin in addition to on-site supervision regarding my clients at my place of employment.

Additionally, the employment supervisor and undersigned supervisor have agreed to inform each other if the supervisee fails to act in accordance to professional code of ethics. The undersigned supervisor agrees to inform the employing supervisor of any problems and concerns regarding the supervisee’s professional behavior.

It is agreed that the employing supervisor holds authority over the off-site supervisor regarding management of client crisis/emergency situations.

**Supervision Frequency, Duration and Context (Off-Site Supervision)**

* Off-site supervision will take place at the office of Laura McLaughlin, LMFT, LMHC.
* Off-site supervisor will primarily be responsible to work with supervisee around theory and intervention strategies for presented cases.
* Off-site supervisor will assist supervisee in preparation for state licensure.

**Supervision Frequency, Duration and Context (On-Site Supervision)**

* On-site supervision will take place with (*name of on-site supervisor*)
* On-site employment (*name, address & telephone #*)
* On-site supervisor will be primarily responsible to work with supervisee around issues related to policies and procedures of the agency, clinical record keeping and risk management of clients.

**Supervisee’s responsibilities under contract**

* Supervisee will inform on-site supervisor of cases presented in off-site supervision as is necessary and requested.
* Supervisee will not transport any materials off-site.

Supervisee is responsible for obtaining consent from employer and returning a signed copy to off-site supervisor. In addition to notifying all parties until supervisee is no longer in need of supervision for licensure purposes, supervisee leaves or is asked to leave place of employment.