

Feedback:

Therapy is a relationship between the two of us. As with any relationship, there is the possibility of ups and downs, communication concerns, misunderstandings, etc. If, at

any time, you feel that your needs are not being met or you are not getting what you want out of the therapy, please tell me so we can discuss your needs and adjust your treatment as needed. Your needs are important to me and there is considerable research that says that open communication between client and therapist regarding adjustments in approach, style, content, and communication improve your outcomes in the therapy process.

Session Time and Attendance:

Therapy is scheduled at a time of our mutual convenience. The day and time for your next session will be scheduled at the close of each therapy session or may be scheduled by telephone or email. Please understand that the time scheduled for your therapy is held specifically for you. Any requests by other clients for the same hour are declined. You are responsible for keeping this appointment and **you are financially responsible for the session regardless of your attendance.** I will make reasonable efforts to reschedule sessions when notified in a timely manner.

I (client) understand the Session Time and Attendance sub-section of the Therapy Agreement:

Client (or Guardian) _____ Date: _____

Conclusion of Treatment:

I fully support the termination of treatment when you have come to a place that feels right to do so. You may end your treatment at any time by providing me with one week’s notice. Deciding to end treatment is your decision, however as anticipating terminating treatment and actually terminating are generally relevant therapy issues, you understand that you are encouraged to make every effort to discuss this decision with me. Again, I support the termination of treatment at the time of your choosing – I am committed however to doing so in the most healthful fashion and that requires that we talk openly about ending our work together when that time comes.

Acceptance of this Agreement:

Your signature on the attached Client Profile indicates that you have read the Therapy Agreement, that you consent to treatment, and agree to abide by its terms during our therapy relationship



KYLE WILLIAMS LMSW ACSW

Solution Focused Individual and Family Therapy

CLIENT PROFILE

* Please skip information below that is irrelevant – alternate addresses, phones, etc

Date Prepared _____

Name: _____

Mailing Address: _____

City/State: _____ Zip: _____

Telephone: _____ Messages OK? Y / N

Text: _____ Messages OK? Y / N

E-mail Address _____

(For your privacy, telephone, text and email messaging is for appointment purposes only – not for discussion of therapy related issues)

Date of Birth: _____

(Optional) Emergency Contact: _____

Relationship: _____ Phone: _____

Your signature below acts as consent to treatment and indicates that you have read the information in the **Therapy Agreement** and agree to abide by its terms during our therapy relationship. You can sign or type your name

Client _____ Date _____

Therapist _____ Date _____