



College of Liberal Arts and Human Sciences

The Family Therapy Center of Virginia Tech

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www.familytherapy.vt.edu/ftc.html

The Family Therapy Center of Virginia Tech Therapy Agreement

Agreement to Treatment

I give my permission to participate in therapy, screening, assessment, or diagnostic evaluation provided by the Family Therapy Center (FTC) of Virginia Tech to treat me individually, or my couple and/or family relationships. These services may be provided face-to-face or via telehealth. Choosing to participate in face-to-face services will require me and/or my family members to meet with my assigned therapist onsite at the FTC.

FTC telehealth services involve using the telephone and/or a secured audio-visual platform. The use of telehealth services permits me and/or my family members to have real-time communications with my therapist. To comply with Virginia state requirements my therapist and I/my family members must be physically in Virginia at the time of telehealth service delivery.

My therapist will discuss my options for receiving face-to-face and/or telehealth sessions at the beginning of my therapy and, as needed, over the course of my treatment. I understand that telehealth services are being offered to allow for service delivery during the COVID-19 outbreak. When deemed appropriate by staff at the FTC, I understand that I will shift to face-to-face therapy sessions with my therapist and that telehealth services may no longer be available to me.

I am aware that, at any time, I have the right to change my decision to receive services. In such cases, I have the right to temporarily suspend my services, or request a referral to another provider. I am further aware that, if my therapist believes I would be better served by another form of intervention (e.g., more intensive and/or comprehensive services than provided at the FTC) or that the services provided at the FTC are not the best way to meet my needs, I will be referred to another provider.

Understanding of Therapy Services

I understand that there are potential benefits to participating in therapy sessions. Despite my efforts and the efforts of my therapist, I understand that therapy may sometimes lead to unanticipated emotional stress as well as relief and growth, and that the FTC does not guarantee any particular results or outcome from the therapy process.

Telehealth Services

To receive telehealth services from the FTC, I understand that I am responsible for:

1. providing the electronic device(s), such as a telephone or a computer with a webcam and/or audio capability, and the internet access necessary for my telehealth sessions,
2. maintaining the security of my electronic device(s),
3. arranging a location in the state of Virginia with sufficient privacy that is free from distractions or other intrusions and
4. maintaining a secure internet connection (instead of public/free Wi-Fi). I understand that my therapist will guide me in the use of the technology associated with our telehealth sessions.

I further understand that there are potential risks associated with participating in telehealth services. I understand that my therapist uses secure audio-visual transmission software to deliver telehealth services; however, it is still possible that my personal information could be obtained by an unauthorized third party. I agree that my therapist or I can discontinue any telehealth session if we believe that the audio/video connection or setting is not adequate to insure my confidentiality and privacy. I also understand that my therapist will stop any telehealth session immediately if an unauthorized party attempts to participate in any way.

Despite reasonable efforts on the part of my therapist, I understand that my telehealth sessions may be disrupted or distorted by technical failures or difficulties. If this occurs, my therapist will make a good faith effort to troubleshoot and/or restore contact using the telephone or the chat feature of the audio-visual platform. If contact cannot be restored relatively quickly (within 15 minutes or so), the telehealth session will be rescheduled.

I understand that my therapist will wait 15 minutes for me to join any scheduled telehealth session. After that time, I understand that my therapist will not necessarily be available, and I will need to contact my therapist through our agreed upon contact phone number (i.e., FTC therapist voicemail or Google Voice) to reschedule.

Agreement to Contact

While receiving therapy services from the FTC, I understand that I will contact my therapist through the university voicemail system, unless I agree to communication via Google Voice. If I choose to use Google Voice I acknowledge that Google Voice is inherently insecure and could result in an unauthorized disclosure of my information. If at any time, I decide that I want to change how I communicate with my FTC therapist, I will notify my therapist immediately so that my therapist is able to document my new communication preferences.

I authorize my therapist to contact me through Google Voice (initial response).

Yes No

All calls are generally returned within 24 hours, during weekdays. To facilitate communication with my therapist, I agree to maintain my phone in such a way that my therapist has the ability to leave me voicemail messages.

If I need to cancel or change my therapy session, I agree to notify my therapist via the therapist's direct FTC voicemail. Alternatively, if I have agreed to have contact with the therapist via Google Voice, I will notify my therapist through their Google Voice phone number, at least 24 hours in advance. Therapists will not receive texts via Google Voice.

I understand that, regardless of the type of therapy (i.e., face-to-face sessions or a secured audio-visual platform) I use, I will receive email information about attending my sessions and completing weekly assessments. I agree to supply my email address to the FTC for this purpose, and to receive communication about my sessions via FTC administrator-approved email accounts (vtftcreminders@vt.edu and mftprn.noreply@gmail.com). I should not respond to the emails I receive from the FTC, and I should never share confidential information through email. If need to communicate with my therapist, I will do so over the telephone, as described above. I authorize contact with me through the two FTC administrator-approved email accounts noted above.

If yes, please type your email address here: _____

Electronic Recording and Observation

Because the FTC is an educational facility and part of the doctoral program in marriage and family therapy at Virginia Tech, I agree to allow electronic recording and observation of my therapy sessions through a secured audio-visual platform. I understand that only FTC administrators, staff, clinical supervisors, and/or authorized visiting mental health professionals will be allowed to view these recordings or to observe actual therapy sessions. Any authorized viewer will treat my information with strict confidentiality, except as noted below in the "Exceptions to Confidentiality" section below. I recognize that the electronic recording of all sessions is a requirement of therapy. Observations of sessions by authorized viewers will occur at the initiation of my therapist or my therapist's supervisor.

The electronic recordings of my therapy sessions will be stored on an encrypted, university-issued computer assigned solely to my FTC therapist for clinical use or on a secure audio-visual recording system housed at the FTC. My therapist will delete recordings of my therapy sessions at regular intervals, as instructed by FTC administrators.

I understand that these recordings are for educational supervision and that I may not photograph, or record any part of a therapy session, whether face-to-face or telehealth, and doing so may result in termination of FTC services and referral to another agency.

Confidentiality

I understand that the FTC maintains electronic medical records. These records, and other information concerning therapy, will be kept in strict confidence by my therapist, FTC administrators and staff, or anyone otherwise affiliated with the FTC. Therapists and FTC staff may not give information about my therapy to others, including the fact that I, and/or my family members are in treatment except as required below or with my consent. If I attend

therapy sessions with my partner or any other adult, everyone attending the session(s) must agree in writing for records of joint sessions to be released to any third party.

Exceptions to Confidentiality

I understand that my therapist or FTC staff may be legally or ethically required to divulge information without my permission under the following circumstances:

- To report evidence or suspicion of child or adult abuse or neglect, with or without client consent, including any evidence or suspicions formed during treatment.
- To report threats to physically harm others or myself that I, my family members, or those involved in sessions with me may make.
- When ordered by a court of law.

Finally, if I develop COVID-19 or am experiencing COVID-19 symptoms, I understand that my therapist and the FTC staff may be legally required to report this information to the local health department.

Participation in Research

All clients 12 and older presenting for FTC services will be asked to complete assessments to guide clinical interventions. In addition to documentation you complete, your therapist will input treatment planning information (diagnosis, treatment goals, progress on goals, session information, treatment model, and reason for termination). This assessment data will only be used for research if you consent to participate in research.

I understand that whether I take part in the research or not, it will take me approximately 45 minutes prior to attending the initial intake appointment to complete the questionnaires on an iPad, smartphone, or computer. The questionnaires will be emailed to the email address provided by me. I will complete an Intersession Report and a Therapeutic Alliance measure before every session following the initial intake appointment. It will take approximately 10 minutes to complete these two measures. In addition to these measures, every 4th, 8th, 12th, 16th session of therapy, and then every eight sessions of therapy afterwards (e.g., 24, 32, 40, 48, etc.), I will complete the questionnaires completed at the initial intake appointment. It is expected to take approximately 30 minutes to complete these questionnaires prior to follow-up appointments. The measures and assessments are available at my request.

Responses to the questionnaires I complete and the information provided by my therapist are stored on a server housed at a collaborating institution. To maintain confidentiality, data will be stored using only my name and my therapist's name; however, both my therapist and I, will also be assigned a unique ID number. While my therapist may access the information with my name included, only ID numbers will be visible when data is downloaded for research purposes by the VT FTC and/or data analysts at collaborating sites for the purpose of collaborating on publications and presentations. The database will be password protected, and only lead researchers will have the password.

I agree to have my information linked by ID number used for research purposes (initial response): ___ Yes ___ No

I agree to have deidentified information of my 12–17-year-old children used for research purposes (initial response and write in child(ren)'s name, if applicable):

___ Yes	___ No	_____	Child 1 Name _____	Not Applicable
___ Yes	___ No	_____	Child 2 Name _____	Not Applicable
___ Yes	___ No	_____	Child 3 Name _____	Not Applicable

Understanding that the FTC is Not an Emergency Service

I am aware that the FTC is not an emergency or 24-hour service. In an emergency, I will call the RAFT Crisis Hotline (540-961-8400) or 9-1-1, or will proceed to the nearest hospital emergency room for help.

Understanding of FTC Fee Collection

I understand that I will be billed for an agreed upon session fee and I will pay the agreed upon amount (as noted on the paper copy of the FTC Client Payment Plan that I and/or my family member/representative will sign). I will promptly return the signed paper copy of the FTC Client Payment Plan to the FTC office in the self-addressed, stamped envelope provided to me by the FTC Office Manager or I will make arrangements with the Office Manager to drop the signed document off at the FTC prior to my next scheduled appointment.

Consent

By signing my name in the designated area(s) below, I certify that I have received the information contained in this document and have been given the opportunity to ask questions and have them answered. I fully understand and agree to participate in therapy services offered by the FTC.

Client Signature (Adult -18 or older)/Date

Client Printed Name

Legal Guardian Signature/Date
(For any minor client; Mark "NA" if no minors)

Legal Guardian Printed Name
(For any minor client; Mark "NA" if no minors)

Printed name of EACH minor client; Mark "NA" if no minors

FTC Staff/Therapist Signature/Date

FTC Staff/Therapist Printed Name

Updated: 9/19/2021