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COUPLE'S INFORMED CONSENT FORM

We agree to share responsibility with Dr. McLaine for the therapy process, including goal setting and terminating. By entering into couple's therapy, we accept that we both understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful in order to reach therapy goals. We understand that the changes one or both of us makes will have an impact on our partner and on others around us. We accept that such changes can have both positive and negative effects and agree to clarify and evaluate the potential effect of changes while undertaking them, especially if we have dependent children.

We understand that couple's therapy begins with an evaluation of our relationship, past and present. While Dr. McLaine is deciding whether she is the appropriate therapist for us, we will decide whether we wish to pursue couple's therapy with her. We understand that, because of the commitment of time and money, plus the potential impact on us and others, it is important to make an informed choice for a couple's therapist.

We have read and understand the potential limits of confidentiality including those imposed by Dr. McLaine's policies and by Virginia law and we have received a copy to keep. If we have dependent children we have read and understood the potential limits of confidentially regarding access to records in child custody cases.

We understand that informed discussion in couple's therapy is for therapeutic purposes and is not intended for use in any legal proceeding involving the partners. We agree not to subpoena Dr. McLaine to testify for or against either party or to provide records in a court action and realize that she will do everything in her legal and professional power not to testify for or against either person.

We understand all polices in the Notice of Privacy Practices Sheet and accept them as conditions for entering into couple's therapy with Dr. McLaine. We understand the limits and benefits if using insurance to pay for couple's therapy. If we use insurance, we agree to provide all information needed to comply with insurance regulations. We understand that if we use insurance, Dr. McLaine will not retain control over information provided to the insurance company.

We have been given the opportunity to ask questions and to discuss confidentiality and disclosure policies with Dr. McLaine. We understand that while working as a couple, anything either of us might say to Dr. McLaine individually whether by phone or in an individual session, may not be held as confidential and at Dr. McLaine's discretion, may be shared with the spouse's partner in a subsequent couple's session (For instance, when facilitating couple's therapy Dr. McLaine will not collude in knowing that one partner continues to have an affair while stating in treatment that the affair is over.)

We agree to share responsibility with Dr. McLaine for the therapy process, including goal setting and termination. By entering into couple's therapy, we accept that we both understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. We understand that the changes one or both of us makes will have an impact on our partner and on others around us. We accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them.

[Dr. McLaine has explained that her therapeutic focus in couple's therapy is on preserving and enhancing the relationship rather than a focus on individual happiness. If remaining together is harmful to one or both partners, the focus will be on facilitating an amicable separation.]

We agree to pay for all services provided by Dr. McLaine including any charges not fully reimbursed by the insurance company. We understand that no insurance company will pay for missed sessions, and we agree to Dr. McLaine's policy of charging if we fail to cancel appointments in advance.

By signing below, we agree to accept mental health services from Dr. McLaine and accept full responsibility for payment for such services.

Patient_____ Date_____
Patient_____ Date_____