Mending Fences Institute

Beth H. Ross bethhross@aol.com Office: 781-821-4606
866 Washington Street Canton, MA 02021

Client _____
Client # _____

Mending Fences Institute Agreement

You are seeking a therapist to help you and/or your family to mend relationships and, process past and present issues that may be impacting your ability to have good working relationships.

Although you will have specific goals, the goals of our working together includes the following:

The goals of Counseling for you and others to:

1. Active involvement in the therapeutic process which may involve work outside of sessions.
2. Promote and establish polite business like interactions with others regardless of how you feel about them.
3. Sharing experiences that make you uncomfortable and have feelings like shame, sadness, guilt, anger, anxiety or frustration. Remember the therapist is here to help you process experiences but can only do so if you share them with the therapist.
4. Talk through situations so as to develop a plan moving forward.
5. Understand the weakness of others and be respectful of them and play to their strengths.
6. Have a thorough understanding of how you have contributed to the conflict and how your actions have affect the relationship.
7. Own your part in the conflict and acknowledge it to others within sessions.
8. Be involved in finding solutions that builds trust, good will and improve your relationship with others.

I agree to

1. Complete forms, and sign releases and agreements
2. Pay bills or replenish your retainer on time.
3. Ensure that you and others attend therapy regularly if needed.
4. Ensure that you and others meet with therapist individually or in any combination of others that the therapist deems appropriate.
5. Be available by phone to discuss any current conflicts.
6. Encourage and include others that are contributing to the conflict to participate in therapy.
7. Commit to do your best towards resolving any issues that are interfering with your relationships and find new ways to interact going forward.
8. Work toward meeting goals you and your family have for yourselves.

Therapist will

1. Evaluate and assess the entire situation as well as past history.
2. Gain a clear understanding of your and/or every person's perspective.
3. Develop a plan and goals with specialists, you and others that are in the best interests of you and family members.

4. If your therapy involves the family understand that therapy will be family centered, not client centered. Therefore the therapist determines the goals of treatment not any one individual client.
5. If you are in individual therapy, goals with be client centered.
6. Establish clear rules of engagement that will foster trust and a good working relationship among you and others and help to establish rules going forward.
7. Help individuals to develop respectful and polite communication with each other as if business associates.
8. Identify behaviors that are causing conflict and help you and others to find alternative ways of dealing with situations.

Therapy is often very difficult work for you and all family members. Because of the current situation it may be very hard to forgive, to trust and to work together again. It may be very difficult to forgive yourself once you realize your part in the conflict. In therapy you will need to look at how you may have contributed to the conflict but also what strengths you have to improve the situation.

There are times when you may feel that the therapist is taking a side; you may want to stop therapy; or want to switch therapists. Discuss these thoughts and your actions with your therapist, you may find an alternative and better approach to the situation.

You may wish to enlist other family members or children to side with you against other family members. **This hurts the family and especially your child/ren.** It is important that you support a positive relationship with all family members and therapists.

Be advised that the therapist's role is to work with relevant family members Reasonable efforts will be made to keep most information confidential.

Costs: Therapy may or may not be covered by insurance. If not covered by insurance, the hourly rate is $150/hour for sessions, phone calls, emails, consultation with specialists, preparation of documents and court time. You and/or family members are expected to pay an initial retainer of $_____ which is put in escrow and to replenish the retainer when it reaches $_____.

If covered by insurance, I/we authorize Beth H Ross LICSW to bill our insurance. I/we will each be responsible for the costs.

I/WE wish to engage in therapy to as quickly, simply and sensibly as possible to resolve my/our difference and issues and work towards solutions. . I/we have read this agreement carefully and am willing to actively participate in therapy.

I/we consent to therapy with Beth H, Ross, MSW, LICSW and to follow her recommendations.

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I/We give Beth H. Ross LICSW permission to talk with other family members with my consent and to share information that is relevant to the resolution of conflict and for healing.

For Child

I/we give Beth H. Ross LICSW permission to treatment and share information about the child/ren listed below which may include individual, family, or group psychotherapy, counseling and testing.

I/we certify that I am/we are the parent/s or legal guardian/s and authorized to make decisions regarding the listed children:

Children's Full Names **Date of Birth**

_____

_____

_____

I/we understand that therapy is voluntary, that either party may withdraw at any time. I/we have signed this agreement willingly and without coercion.

All matters discussed during the psychotherapy sessions or consultation are confidential and privileged thus protected under HIPAA. Disclosure may be required pursuant to a legal mandate or proceeding and may be disclosed to other members of the therapeutic team as needed to advance the healing of clients. I/we understand that all material and communication is confidential. I have read the HIPAA Confidentiality Agreement and understand my rights.

To the best of our ability I/we agree to discourage or stop words and actions that escalate conflict. I/we understand that the in family therapy the therapist is in charge of the process and we agree to follow the plan and work towards the goals.

I have read the Mending Fences Policies and General Information and agree to the terms.
I have read the electronic communications authorization, understand the risks and agree to use electronic communication.

My signature below will verify that I have read and understand the above agreement and will follow the therapist's recommendations and office rules and policies to the best of my ability.

Date **Print Name** **Signature**

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