

## COLLATERAL/GUEST THERAPY CONSENT

The purpose of this form is to allow a "collateral" or "guest" to participate in a therapy session as a third-party participant. The role of a collateral/guest can vary according to his/her relationship with the client. The therapist will discuss the role in the client's treatment during the first session the collateral/guest participates.

The collateral/guest, \_\_\_\_\_, will attend sessions upon the request and permission of the client, \_\_\_\_\_.

The purpose of collateral/guest's participation is to provide information to the therapist about the client, both factual and from his/her personal perspective, in order to help the client achieve treatment goals. During sessions, the collateral/guest may also be asked to participate in exercises to help further the client's treatment, or to support the client in other ways.

The collateral/guest will not be considered a client of \_\_\_\_\_ (therapist/practice) and will not use this attendance for his/her own therapy needs. The therapist's legal and ethical responsibility resides strictly with the client.

I, \_\_\_\_\_ (client), do hereby authorize \_\_\_\_\_ (collateral/guest) to participate in my counseling sessions with my therapist, \_\_\_\_\_.

I, \_\_\_\_\_ (collateral/guest), understand that my participation is voluntary, and that at any time I can decline to answer any question, to participate in any exercise, or to participate in \_\_\_\_\_'s (client) therapy sessions.

By signing below, both client and collateral/guest understand and acknowledge the following:

1. All information discussed during a counseling session is to be kept confidential and private.
2. The therapist will not be liable for any violations of confidentiality or privacy by the collateral/guest.
3. Participation in counseling sessions does not grant the collateral/guest access to the client's medical records.
4. The client can terminate the collateral/guest's participation at any time.
5. If the client wants the therapist and collateral/guest to communicate when the client is not present (email, phone), the client must complete an "Authorization to Release Information" form.

Printed Name of Client: \_\_\_\_\_

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Collateral/Guest: \_\_\_\_\_

Signature of Collateral/Guest: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Therapist: \_\_\_\_\_ Date: \_\_\_\_\_