

ERIKA BISCHOFF, LCSW

CBT Therapist

ADDENDUM TO CONSENT FORM: COUPLES THERAPY

By signing this document, I agree to the following conditions of couples therapy:

1. I am aware that Erika Bischoff, LCSW will keep one confidential record that documents our work as a couple (dates of sessions, progress notes, etc.). The contents of this medical record may not be released to any person without the written consent of both the named clients on this form, except as required or permitted by law.
2. I understand that information discussed in couples therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners.
3. I acknowledge that we are jointly responsible for the costs of couples therapy.
4. I am aware that Erika Bischoff, LCSW is authorized to share confidential information between both named clients on the form regarding treatment for couple's therapy. It is understood that in couple's therapy that there are no secrets between all parties.
5. I am aware that this form supplements, but does not replace, other consent forms and HIPAA policies to which I have already agreed.

Name of clients in couples therapy:

CLIENT #1

CLIENT #2

PRINTED NAME

PRINTED NAME

CLIENT NAME FOR SIGNATURE: _____

SIGNATURE

DATE