



Aleya Littleton, MA, TAP, Adventure Therapist | www.wwlcounseling.com | (708)
740-0136

CONSENT FOR SERVICES

I voluntarily apply for and consent to receiving psychotherapeutic services, either for myself or for my dependent; (name) _____, (relationship) _____; including evaluation, assessment, diagnosis, and treatment by Aleya Littleton, MA, TAP of Wild and Wonderful Life Counseling. Additionally, I am aware that psychotherapeutic, counseling services are not based on an exact science and that the type(s) of treatment I receive will depend primarily on my own needs and abilities. I understand that, as such, I cannot be given any guarantees about the results of any of these services. Further, I also understand that I may withdraw this consent at any time.

I understand I am an active participant in the process of establishing, evaluating, and accomplishing my goals for therapy and demonstrate this by my ability and willingness to communicate my ideas, thoughts, feelings, needs, likes, and dislikes. I understand that by naming and negotiating my needs openly and clearly, and by bringing my full attention and awareness into this process, I am empowered to respect and care for myself.

The three basic therapeutic agreements expected of me are:

- 1) Telling the truth to the best of my ability
- 2) Acknowledging my feelings, thoughts, needs, and sensations at a fundamental level
- 3) Honoring my agreements with my therapist or renegotiating existing ones to meet my needs if my needs change

I understand that making a commitment to these three basic agreements facilitates and accelerates the creation of an environment that enables me to reach the goals I have established with my therapist. If at any point I do not feel I can continue to commit to these agreements, I will inform my therapist.

DISCLOSURE OF INFORMATION

I understand that information will only be shared in accordance with HIPAA regulations.

I understand that any release of verbal, written, and/or electronic information about my therapeutic relationship must occur with my written consent, with a few exceptions. These exceptions include the possibility of imminent danger to me, imminent danger to others, or if I am not able to safely take care of my basic needs because of a disabling condition.



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I understand that some aspects of my therapeutic relationship will be shared with other clinical and administrative staff on a need to know basis. These situations include, but are not limited to, clinical supervision, mentoring, back-up coverage, invoicing, and scheduling.

I understand that that my signature for consent to release information must be directed to an identified individual for an identified purpose for an identified period of time.

I understand that if I am a parent or guardian of a minor age child or children, I must sign an acknowledgement of the need for mandatory disclosure of abuse or neglect of any minor age child or children.

I understand that information about me as the client can be electronically transferred for the purposes of filing insurance claims or seeking professional consultation.

I understand that providing an email address for my therapist to use when contacting me presumes my understanding that this form of communication cannot be guaranteed to be confidential and I release him or her from any unintentional liability that this may incur.

I understand that providing a cellular telephone number for my therapist to use when calling me presumes my understanding that this form of communication cannot be guaranteed to be confidential and I release him or her from any unintentional liability that this may incur.

I understand that information may be transferred by facsimile if deemed necessary to expedite services when appropriate releases of information have been signed.

I understand that all written, video, auditory, and electronic communications and records are protected by this policy. These records are maintained in a locked or password protected environment and stored according to the policy. These records are maintained in a locked or password protected environment and stored according to the requirements of the Colorado Mental Health Statute.

Other information specific to mandatory disclosure of information is further delineated in the Client Disclosure Statement Form and I have read and understand this information.

FEES AND PAYMENT



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I understand that the fee for individual, couple, and family psychotherapy is based on the private pay rates established at the time of service, at the time of renegotiation, or on the contracted rates as established by any third party payment source at the time of service. Other options for payment of services may be available and can be discussed on an individual basis.

I understand that all fees are due at the time of service.

I understand that I may have no more than two outstanding payments at any given time and that I will not be able to schedule my next session until these payments have been made.

Other information specific to fees and payment is further delineated in the Fee Agreement Form and I have read and understand this information.

NUTRITION AND FITNESS SUPPORT POLICY

I understand that Aleya Littleton has specialized knowledge in nutrition and/or fitness and might ask about my nutritional intake or fitness practices. I also understand that she may even suggest outside sources for further consultation in these areas.

I understand that when such suggestions are offered they are provided merely as avenues for further exploration and are not meant to be seen as prescriptions, directives, or therapeutic mandates of any sort.

I understand it is my responsibility to seek out and consult with appropriately trained professionals for further information about any of the suggestions offered to me Aleya Littleton.

I understand clearly that I am not a medical “patient” of Aleya Littleton and will not be “diagnosed,” “cured,” “treated,” or “prescribed” any medications for my ailments, diseases, health, or lifestyle as this is considered practicing medicine without a license. I understand that Aleya Littleton is not licensed to practice medicine and any suggestions for nutritional or fitness support should not imply so.

I personally assume ALL risks involved with the consumption and/or application of complementary/alternative medicines or treatments that I initiate on my own.

GIFT POLICY



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I understand that the giving and receiving of gifts within the therapeutic relationship has the possibility of clouding or confusing the nature and scope of my personal process with my therapist and thus I will refrain from giving or receiving gifts as a part of my therapy.

I understand that the fee I pay for services is the only remuneration I am expected to contribute toward the cost of my therapy and that it is not expected or recommended that I give gifts to my therapist or that my therapist give gifts to me.

I understand that if it is determined that gifts will be given, by either me or my therapist, that the cost of the gift must be lower than \$25.00 and that there will be an explicit conversation about what the gift means BEFORE the gift is given or received.

TOUCH POLICY

I understand that Aleya Littleton has specialized training in the use of therapeutic touch, and that touch may be required in the implementation of adventure therapy interventions for safety reasons.

I understand that occasionally there are times when the use of touch might be beneficial in the therapeutic process, such as to facilitate awareness of tension in my body or to encourage the completion of an unfinished movement sequence.

I understand that though touch might be helpful at these times, the use of touch is never essential or mandatory and will not be initiated or continued if I am at all uncomfortable with being touched or if my therapist at any point determines that touch is contraindicated.

I understand that if touch is used, my therapist will first request permission from me before using it. I also understand that I may say “no” at this first request and that I may always verbally decline my consent for touch at any point thereafter.

AVAILABILITY AND ANSWERING SERVICE

I understand that telephone calls and electronic communications can be received at any time via telephone, telephone voice mail, and/or email. It is important to note that when calls ring into voice mail, the messages are picked up regularly and will be returned as soon as possible. If I have a major emergency and cannot reach Aleya Littleton, I am aware that I may need



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to seek help at a mental health center or a local hospital. Within the Denver/Boulder metropolitan area, I can always access assistance by dialing 9-1-1 on my telephone.

REPORTS AND PHONE CALLS

I understand that there is no charge for brief phone calls, messages left on voice mail, and/or electronic communications. Calls or emails lasting longer than 10 minutes will be charged to me on a pro-rated basis. Reports requested by insurance companies, physicians, etc, will not be released without my permission. Charges for reports will be pro-rated based on the private pay rates established at the time of service, at the time of renegotiation, or on the contracted rates as established by my insurance company at the time of service.

CANCELLATION POLICY

I understand that at least 24 hours advanced notice must be provided if I need to cancel or reschedule a session. Because my appointment time has been reserved specifically for me, all changes or cancellations received with less than 24 hours notice will be billed at my regular rate unless my appointment can be rescheduled within the same week.

TERMINATION OF THERAPY

I understand that if I feel I am approaching readiness to leave therapy I will speak with Aleya Littleton regarding this. Likewise, if my therapist feels I am approaching readiness to leave therapy, this will certainly be discussed with me as well. Additionally, my progress and status will also be discussed and reviewed with me on an ongoing basis.

I understand that I may seek a second opinion from another therapist or may terminate therapy at any time. If I do decide to terminate therapy, I agree to inform my therapist as far in advance as possible, or if this is not possible, at the beginning of the last session at which I am to meet. In a therapeutic relationship of any length, termination and closure are very important processes and most people find their experience to be incomplete if there has not been an adequate opportunity to discuss the reasons for ending. Advance notice also allows both me and my therapist to pace the therapeutic process appropriately.

I have read the preceding information and I agree to the aforementioned terms:



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Client Name: _____

Client Signature: _____ Date: _____

Therapist/Witness: _____ Date: _____