SECTION: PRACTITIONER AND SERVICE DETAILS

Section Heading

Psychologist name:

Registration No

Practice:

Contact details:

- M:

- E:

- P:

Treatment modalities: Gottman Couples Therapy, Emotional Processing Therapy for Couples, Cognitive Behavioural Therapy, Existential Psychotherapy, Schema Therapy, Cognitive Processing Therapy. Motivational Interviewing, Cognitive Processing Therapy.

SECTION: NEXT OF KIN AND FAMILY INFORMATION

Section Heading

*** 1. Next of Kin - name**
*** 2. Next of kin - phone number**
3. Next of kin - email address
4. Names and ages of any children

SECTION: OCCUPATION

Section Heading

*** 5. What is your current occupation?**

SECTION: PURPOSE AND NATURE OF COUPLE THERAPY

Section Heading

The purpose of couple therapy is to help both partners improve communication, resolve conflicts, and enhance relationship connection, satisfaction and functioning.

- The process involves 4 stages:

1. Assessment phase

2. Therapy phase

3. Maintenance phase

4. Relapse prevention phase

- Therapy is not relationship advice from a legal or financial perspective;

- Therapy is not problem solving;

- Therapy focuses on relational patterns, communication, and emotional processes;

- Therapy does not guarantee success.

*** 6. In clicking yes – I have read and understood the above section and agree to abide by these conditions.**

SECTION: POTENTIAL RISKS OF THERAPY

Section Heading

Engaging in couple therapy can bring many benefits, but it also carries potential risks that clients should consider. These may include :

- emotional discomfort or distress as difficult memories, thoughts, or feelings are explored;

- the possibility of temporary worsening of symptoms or anxiety between sessions;

- potential impacts on self-identity or worldview as new coping strategies are tested;

- the chance that progress may be slower than hoped or require a longer course of treatment than anticipated.

- in some cases, adverse reactions to certain interventions may occur.

It is important for clients to discuss these risks with XXXXX, establish a clear plan for safety and crisis support, and have regular reviews of goals, progress, and any concerns.

*** 7. In clicking yes – I have read and understood the above section and agree to abide by these conditions.**

SECTION: EMERGENCY AND CRISIS PROCEDURES

Section Heading

Please Note: While XXXX attempts to be as responsive as possible to out of session contact (emails responded to within 48 hours). They cannot and does not provide a crisis service.

- In case of a crisis or immediate danger, clients will be advised on appropriate 24/7 supports (e.g., Lifeline 13 11 14, emergency services 000 in Australia) and local crisis hotlines.

*** 8. In clicking yes – I have read and understood the above section and agree to abide by these conditions.**

SECTION: ASSESSMENTS AND DISCLOSURES

Section Heading

- If psychological testing or standardized measures are used, clients will be informed about the purpose, potential risks, and how results will be used and stored.

- Clients will be provided with a copy of any reports or assessment findings when appropriate and with consent.

*** 9. In clicking yes – I have read and understood the above section and agree to abide by these conditions.**

SECTION: CONFIDENTIALITY AND LIMITS

Section Heading

Please Note: Couple therapy is a completely transparent process therefore XXXXXX is unable to hold secrets from your partner. Additionally, once the assessment process has been completed XXXXX will not engage in individual communication outside of consultation sessions, all emails, text messages etc must include both partners for XXXXX to be able to respond.

Clients should be aware that the establishment and maintenance of confidentiality between a psychologist and a client are fundamental to professional practice. In the event that the psychologist feels it is necessary to disclose confidential information, the matter will first and foremost be discussed with the client and, where possible, written consent will be obtained. Should you require additional information about confidentiality, please feel free

to ask to see a copy of the Code of Conduct enforced by the Australian Health Practitioners Regulatory Authority (AHPRA).

What will be kept confidential:

- Personal information, assessments, and session notes will be kept confidential and stored securely in line with Privacy Act 1988 and Australian Privacy Principles.

- Client information will be de-identified when used for supervision, training, or research unless explicit consent is given.

Limits to confidentiality:

- If there is a risk of harm to self or others, or if there is a legal obligation (e.g., mandatory reporting requirements under state/territory law, child protection, elder abuse), information may be disclosed to appropriate authorities or professionals without the client's consent.

- Court orders or subpoenas may compel disclosure.

- Information shared with third parties (e.g., family members, carers) requires explicit written consent unless there is a risk to safety or other ethical/legal exceptions apply.

Data storage and retention:

- Records (assessment reports, progress notes, consent forms) will be stored securely (electronically with password protection and encryption; hard copies in locked storage).

- Retention periods will comply with relevant legislation; typically a minimum of 7 years after the final session, or as required by state/territory regulation.

Telehealth and digital communications:

- as therapy will be provided via telehealth, steps will be taken to ensure privacy and data security; both client and clinician should be in private, secure environments.

*** 10. In clicking yes – I have read and understood the above section and agree to abide by these conditions.**

SECTION: PERMISSION TO SHARE INFORMATION

Section Heading

Information may be required to be shared in the following situations:

- If you are accessing services through an EAP referral;

- If you are accessing service via Open Arms or a DVA referral;

- If records are subpoenaed through any Australian Court.

*** 11. If applicable - please provide your consent for me to share this information with your GP**

SECTION: CULTURAL/DIVERSITY SAFETY AND ACCESSIBILITY

Section Heading

- Efforts will be made to be culturally respectful and to accommodate diverse needs (language support, accessibility, and relevant cultural/diversity considerations).

- Clients are encouraged to discuss any specific cultural or diversity needs at any time.

*** 12. In clicking yes – I have read and understood the above section and agree to abide by these conditions.**

SECTION: RECORDS AND ACCESS

Section Heading

- Clients have the right to access to their personal records in consultation with the psychologist in accordance with Australian privacy laws. If you are accessing records individually you will be required to obtain your partner's signed informed consent.

Please Note: This does not include obtaining copies of records unless records are subpoenaed.

- Requests for access, correction, or amendment of records should be directed to the psychologist.

*** 13. In clicking yes – I have read and understood the above section and agree to abide by these conditions.**

SECTION: INFORMED CONSENT TO RECORD SESSIONS

Section Heading

In the field of psychology and particularly in couples therapy, recording sessions is often

helpful for 3 main purposes:

1. Review of the session by the therapist for increased clarity and therapeutic planning purposes;

2. Peer review of sessions to illicit feedback on professional performance and enable professional development;

3. Teaching aids – to enable less experienced psychologists to learn through observation and analysis of another professional's work.

XXXXX has a preference for recording all consultations to aid her continued development and learning as a therapist as well as to assist the learning of trainee therapists.

*** 14. I understand that all material obtained will be treated with strict confidentiality and I am aware that all reasonable precautions have been taken to ensure personal identification is avoided. I am also aware that cases of current child sexual and physical assault are notifiable and may be reported. I understand that each recorded session may be viewed or listened to by qualified psychologists and/or qualified academic staff for the purposes of professional feedback and teaching. I acknowledge that I have read this form and, by my signature, volunteer my consent to the recording being used for the purposes of learning and training.**
*** 15. I acknowledge that I have read this form and, by clicking yes as a form of signature, volunteer my consent to the recording being used for the purposes of learning and training.**

SECTION: INFORMED CONSENT FOR TREATMENT

Section Heading

- I have read and understood the above information.

- I understand my rights, including the right to withdraw consent at any time.

- I agree to participate in psychological treatment as described.

- I understand that I may request a copy of this consent form for my records.

- I understand the nature and goals of the proposed treatment.

- I understand the potential benefits and risks, including possible emotional discomfort.

- I understand that I have the right to withdraw or modify treatment at any time without penalty.

*** 16. In clicking yes – I have read and understood the above section and agree to abide by these conditions.**

SECTION: AGREED PAYABLE FEES AND CANCELLATION POLICY

Section Heading

Fees for this practice are based on the following schedule unless otherwise negotiated. This Practice uses Auto Payments to pay your appointment fees. These are processed automatically at the time of your appointment. When payment is processed you receive a confirmation email as well as the invoice from your practitioner. If you are using Private Health rebates you will be able to use your invoice to claim your rebate from your Health Fund. The Agreed Payable Fees determined prior to your initial appointment are:

- Telehealth assessment process - XXXX (incl processing fees) payable in advance to confirm your appointment;

- Telehealth marathon day - up to 8 hours including breaks - $XXXX (incl processing fees) payable on the day of service;

- Telehealth individual sessions - $XXX (incl processing fees) per 60 minute session

Cancellation policy –

*** 17. In clicking yes – I have read and understood the above section and agree to abide by these conditions.**

SECTION: CONSENT FOR TELEHEALTH PSYCHOLOGICAL SERVICES

Section Heading

I understand and agree that:

- **Telehealth (video or telephone) is being used to provide psychological assessment, treatment, and related services by.**
- **I have the right to withhold or withdraw consent for telehealth at any time, acknowledging that this would effectively terminate my treatment with XXXXXX and that XXXXX will provide details for up to 3 suitably qualified practitioners who could continue clinical services in person with me/us;**
- **Telehealth may involve risks to privacy and confidentiality, including potential breaches due to technical issues, data storage, or third-party platforms. Steps will be taken to minimize risks, including using secure, encrypted platforms and confirming my identity before sessions.**
- **My personal information and health records will be stored and handled in accordance with Australian privacy laws (Privacy Act 1988) and the practitioner's**

privacy policy, and I have been informed where and how my information will be stored, who will have access, and how it will be used.

- **The limitations of telehealth include potential interruptions, technology failures, and the inability to perform certain physical assessments or in-person observations. If a risk arises that cannot be managed via telehealth, I may be referred or advised to seek in-person care or emergency services.**
- **If I am located outside of Australia or in a different jurisdiction, I understand there may be legal and regulatory limitations, and I have discussed this with my psychologist.**
- **I give consent for the storage, handling, and transmission of my health information for the purpose of telehealth treatment, including audio or video recordings if explicitly requested and with my informed consent, and I understand I can request access or amendment of my records as per privacy laws.**

*** 18. In clicking yes - I have read and understood the above information and agree to abide by these conditions**

SECTION: CONSENT REVIEW

Section Heading

Consent will be reviewed and re-negotiated by 31 December each year.

*** 19. In clicking yes - I have read and understood the above information and agree to abide by these conditions**

SECTION: ELECTRONIC SIGNATURE / ACKNOWLEDGMENT

Section Heading

*** 20. In clicking yes - I have read and understood the above information and agree to abide by these conditions**