

Co-Therapist Information and Participation Agreement Example

This is a sample form for IBH members. Have your legal advisor help you design your own form.

Angela Simmerman Sierra provides the following services:

Clinical hypnotherapy, Self-Hypnosis Training, and Neuro-Linguistic Programming at 2132 Osuna Rd NE, Suite B, Albuquerque, NM, 87113.

International Board of Hypnotherapy Certification Number: F0310-006

This information will be used to aid in serving you as the co-therapist. Please answer honestly and know that answering yes or no to any particular question does not mean that you cannot receive services from this practitioner. Your honest answers serve in your receipt of appropriate care and service. {{Hypnotherapists want co-therapists to answer honestly because the co-therapist may need a referral to a licensed mental health practitioner or physician instead of having hypnotherapy sessions.}} All information will be kept confidential within the Health Insurance Portability and Accountability Act (HIPAA) regulations.

Co-therapist's Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Email Address _____

_____ Initial to agree to the use of email correspondence

_____ Initial to agree to receive customized self-hypnosis MP3 via email, text, or other electronic means, for instance transfer app like *Dropbox* or *WeTransfer*.

Phone number you prefer to be reached at _(____)_____

_____ Initial to agree to receive text messages at this number

_____ Initial to agree to receive voice messages at this number

Online sessions

_____ Initial if you agree to your hypnotherapy sessions being conducted on a video chat platform over the internet.

Age _____ Marital Status _____

1. What is the main issue you wish to resolve with hypnotherapy?

2. Medical conditions or challenges:

3. Are you currently under a physician's care for any of the above conditions?

a) If so, name of physician:

4. When was your last visit with a physician?

5. Was anything about this visit notable? If so, explain briefly:

6. Are you currently taking any medication(s)?

a) If so, what are the names of the medications, and how do they affect you?

7. Have you spoken to your physician about hypnotherapy as an adjunct to your treatment?

8. Have you ever been hypnotized?

a) If so, briefly explain your experience:

9. Have you ever had any mental health treatment, such as with a counselor, therapist, psychologist or psychotherapist?

a) If so, give a brief history of your mental health treatment and the results of your treatment:

10. Are you receiving any mental health treatment now?

a) If so, name of mental health professional:

b) Have you spoken to your mental health professional about hypnotherapy as an adjunct to your treatment?

11. Do you have thoughts of hurting yourself or taking your own life?

12. Do you agree not to use, or be under the effects of, mind altering substances like alcohol, cannabis, ketamine, psilocybin/magic mushrooms, etc., before hypnotherapy or self-hypnosis? ___ yes ___ no

13. Do you take any prescribed psychotropic medications?

a) If so, what are the names of the medications, and how do they affect you?

14. Were you referred to me?

a) If so, by whom?

15. Briefly describe your spiritual/religious beliefs or life philosophy:

Other issues or areas I would like to resolve:

- | | |
|--|--|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Forgiveness |
| <input type="checkbox"/> Guilty or Angry Feelings | <input type="checkbox"/> Relationship Issues |
| <input type="checkbox"/> Fears, Phobias or Trauma Recovery | <input type="checkbox"/> Job Performance |
| <input type="checkbox"/> Low Self Esteem or Shyness | <input type="checkbox"/> Unwanted Habits |
| <input type="checkbox"/> Lack of Motivation | <input type="checkbox"/> Smoking Cessation |
| <input type="checkbox"/> Body Shape | <input type="checkbox"/> Sports Performance |
| <input type="checkbox"/> Spiritual Growth | <input type="checkbox"/> Self Confidence |
| <input type="checkbox"/> Test Taking/Accelerated Learning/Memory Improvement | |
| <input type="checkbox"/> Chronic Pain (already assessed by a physician) | |
| <input type="checkbox"/> Accelerated Healing (already assessed by a physician) | |
| <input type="checkbox"/> Other: | |

[Have your own legal advisor review this before using it.]

Agreement:

I understand that hypnotherapy, self-hypnosis, hypnotherapy regression techniques, processing emotions, guided imagery, neuro-linguistic programming (NLP), and meditation are not absolute sciences. I am of legal age, and in consideration of my acceptance as a participant in this private hypnotherapy or NLP sessions, seminar, or workshop, I for myself, my heirs, my executors, administrators and assignees, do hereby release and discharge your name and any of her employees, her employer, or other participants in any of the activities, from any and all claims of damages arising from, or growing out of my participation in said activities. I agree that any and all complaints or disputes arising from my participation in hypnotherapy sessions, hypnotherapy regression techniques, processing emotions methods, neuro-linguistic programming techniques, guided imagery, meditation, seminars or events, and any other activity related to the above, should it arise, shall initially be decided by the Board of Directors of the International Board of Hypnotherapy (IBH) in accordance with its published procedures for reviewing and deciding complaints against its members (published at www.internationalboardofhypnotherapy.com.) I further agree to mandatory mediation for any claims of damages or disputes before filing suit in a court of law. I further understand that recordings may be made at any of these sessions or events, and that your name and her organization retain the copyright to all of these recordings.

Signature _____ Date _____

If under eighteen years of age:

Legal Guardian: _____ Date _____

Confidentiality of Information

Co-therapists have a right to expect that information revealed in sessions not be disclosed without extraordinary justification. The conditions that justify the release of information and by law must be reported to the appropriate agencies, are the following:

1. Reasonable suspicion of child abuse or neglect.
2. Reasonable suspicion of senior citizen abuse or neglect.
3. A co-therapist poses a serious risk of suicide and is an imminent danger to self.
4. A co-therapist poses a threat of imminent danger to another person.
5. A Judge, by issuance of a court order, may obtain information.
6. Report to law enforcement authorities knowledge of a felony that has been, or is being committed.

In other situations, signed authorization for release of information is required.

Co-therapist _____ Date _____

Hypnotherapist _____ Date _____

[You could provide new co-therapists with a duplicate of this page.]

In order to be more successful in reaching my goals, I agree to:

1. Be an active participant in my hypnotherapy experience and see myself as a partner in the transformative nature of this process.
2. Recognize that my thoughts, feelings, images and actions have a direct effect on the quality of my life.
3. Acknowledge that my well-being depends directly on how well I care for myself physically, emotionally, intellectually and spiritually.
4. Accept that blaming others or myself is totally futile.
5. Take responsibility for my experience of life, because I create my life to the best of my ability in the moment, with what I know right now.
6. I agree to be on time for my sessions and allow at least 24 hours of advance notice should I need to cancel or reschedule a session. (505) 555-5555

I understand that all services provided by your name are for educational and self-improvement purposes only. I further understand that these services are not the practice of medicine or psychotherapy and are, therefore, not offered as a replacement for counseling, psychotherapy, psychiatric or medical treatment.

Hypnotherapy is an educational process that facilitates access to internal resources that assist people in increasing motivation or altering behavior patterns through hypnosis to create positive change. The education of hypnotherapy is classified under Human Services in the Health and Human Services Division of the Classification of Instructional Programs by the United States Department of Education. The services provided are also described in the Dictionary of Occupational Titles published by the U. S. Department of Labor, see code 079.157.010.

If you should have a complaint about the facilitation process that has not been satisfactorily resolved by your name or her organization, please feel free to contact the International Board of Hypnotherapy at 2132 Osuna Rd NE, Ste. B, Albuquerque, NM. It is your right to refuse any aspect of her services and to seek the service of another hypnotherapist at any time. Your name's fee is \$150. Sessions are from 45 to 90 minutes in length.

Co-therapist _____ Date _____

My commitment to you: I will use my expertise to facilitate the changes that are mutually agreed upon to be in your best interest, in the shortest possible time.

Clinical Hypnotherapist _____ Date _____

Your Name, CMS-CHt

Authorization for Release of Information

{Insert your Business Name & Address Here}

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

I understand that this authorization is voluntary, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Client name: _____

Birth date: _____

Client address: _____

I hereby authorize *{Insert Your Name}* to:

(Check all that apply)

☐ Exchange information with _____

☐ Release information to _____

☐ Obtain information from _____

I hereby authorize *{Insert Your Name}* to exchange / release / obtain information:

☐ Verbally ☐ In written form only ☐ Both verbally and in writing

To or from the person/organization receiving/communicating the information:

Name: _____

Address: _____

Phone Number: _____

<p>Note: The release of information form is only given to co-therapist when permission is needed for another provider to speak to you, or when you need to speak to another provider.</p>
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{Insert your Business Name & Address Here}

Authorization for Release of Information - Continued...

Description of Specific Information to be either:

Released/exchanged/obtained:

The specific purpose of this release is to:

This authorization expires on: _____

I have read and understand the following statements about my rights:

I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation.

I may see and copy the information described on this form if I ask for it.

I am not required to sign this form to receive hypnotherapy services

Client signature: _____

Today's date: _____

This is an example of what International Board of Hypnotherapy members are using. You must have your legal advisor help you design your own form that reflects your level of education and legal concepts appropriate to your state or province. **We present all of the above for discussion only.**