



**John Rasberry, LMFT, TEP**

**Psychodrama & Sociometry**

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**THERAPIST/CLIENT CONTRACT**

**JOHN RASBERRY, M.Ed., LMFT, TEP**

I am pleased you have selected me as your therapist. This document is designed to inform you about my qualifications and experience. It also ensures that you understand our professional relationship.

**DEGREES-**

B.S. Social Rehabilitation Services - University of Southern Mississippi

M.Ed Education Psychology with emphasis in Mental Health Counseling-University of Mississippi

**LICENSES-**

Licensed Marriage and Family Therapist

**CERTIFICATIONS-**

Certified Trainer, Educator, Practitioner in Psychodrama, Sociometry and Group Psychotherapy-TEP by the American Board of Examiners in Psychodrama, Sociometry and Group Psychotherapy.

**MEMBERSHIPS-**

Fellow - American Society of Group Psychotherapy and Psychodrama

Member - American Association of Marriage and Family Therapists

Member - Mississippi Association of Marriage and Family Therapists

**NATURE OF PSYCHOTHERAPY-**

I believe that people have the ability to provide, discover and act on solutions to problems. In keeping with my philosophy and training, I believe using action methods and theory best facilitates a client meeting the goals for therapy. Each client is treated as an individual, so length and frequency of therapy may vary from client to client. As a client you control much of our interactions and may end therapy with me at any time. I define therapy as successful when a client meets the goals they have established. Although our sessions may develop emotional and psychological intimacy, it is important to keep in mind that we have a professional rather than personal relationship. You will be best served if our relationship remains strictly professional and we concentrate exclusively on your concerns.

**REFERRALS-**

If, at any time, you desire a referral to another practitioner, I will provide you with that information and assist in the referral.

**COMPLAINTS-**

Please let me know of any complains you might have regarding my performance. If I am unable to resolve your complaint, you may contact my licensing and/or credentialing agencies. I will provide you with the contact information.

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**FEES-**

Individual session 50 min.	\$120.00
110 min.	\$180.00
Family Therapy 50 min.	\$180.00
110 min.	\$270.00
Couples Therapy 50 min.	\$180.00
110 min.	\$270.00

Fees are due and payable at the end of each session unless prior arrangements have been made. Cash, check, credit cards are accepted. Payment is expected at each session. Any balance from your account will be provided to you upon request. Documentation may also be provided to you should you prefer to file your own Insurance.

**RECORDS AND ACCOUNTABILITY-**

All of our communication becomes part of your clinical record which is accessible to you upon request. I will keep confidential anything you say to me, with the following exceptions: (1) you direct me, by signed consent, to tell someone else, either orally or written. (2) I determine you are a danger to yourself or someone else, (3) I am ordered by the court, (4) you are a minor and there is evidence of physical, sexual abuse occurring or has occurred or I have concern for the safety of the minor. (5) In the case of a minor, the guardian or parent requests information.

**INFORMED CONSENT-**

You have the right to know the nature of services that you are receiving. This includes being informed of any potential benefits and risks associated with certain techniques or services. You also have the right to express desired goals and outcomes related to those services.

**YOUR RESPONSIBILITIES-**

- (1) Be on time for all appointments and to give advanced notice of any changes.
- (2) Be an active participant in planning, goal-setting, related processes pertaining to meeting the goals.
- (3) Failure to provide notice of cancellation, reschedule or change of an appointment, prior to 24 hours of the appointment, will result in you being charged for that session.

**CONSENT-**

I have read the foregoing information and understand the policies, procedures, rights and responsibilities as a client. I also understand that the staff (providers and supervisors) may discuss the services being provided to me and that I have the right to be informed of the names of those involved in my care.

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Signature

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Date