CONSENT FOR TREATMENT
WITH ACCELERATED RESOLUTION THERAPY

THIS NOTICE DESCRIBES THE AGREEMENT YOU ARE ENTERING WITH YOUR CLINCIAN

THIS NOTICE BECAME EFFECTIVE ON November 1, 2010

Accelerated Resolution Therapy©, or ***ART***, is a form of psychotherapy treatment which involves the skilled use of eye movements to process negative memories, images, and sensations. ***ART*** is NOT hypnosis. Clients are fully awake throughout the ***ART*** process and can chose to stop at any time.

Upon beginning Accelerated Resolution Therapy©, I have been informed of the risks and benefits which include:

Benefits May Include:

Relaxed, calming effect
Reduction in negative emotions and sensations
Inability to recall distressing images
Ability to remember an event or memory without seeing visual images of the event
Other benefits that vary by person

Risks May Include:

Difficulty recalling events from the past
Inability to see images associated with memories
Lightheaded feeling
If in litigation, the possibility that details may be hard to recall or emotions may no longer match the story of the event.
Others risks that vary by person

Accelerated Resolution Therapy, otherwise known as ART®, is currently an evidence-based psychotherapy treatment approved by the SAMHSA (Substance Abuse Mental Health Services Administration) registry of evidence-based techniques and is listed as approved for trauma, depression, anxiety, and resilience. It is also listed as a promising psychotherapy for Obsessive Compulsive and other mental health disorders.

Distressing, unresolved memories may surface through the use of the ***ART*** procedure. Some clients have experienced reactions during the treatment session that neither they nor the administering clinician may have anticipated, including a high level of emotion or physical sensations.

Distressing memories may seem to disappear while more pleasant memories may take their place during ***ART***. You should therefore check with an attorney **prior** to consenting to ***ART*** treatment if you need to recall events for a legal proceeding.

After ***ART***, these negative memories have been more normally processed and are stored in a location that no longer bothers you, as the client. Subsequent to treatment session, the processing of incidents/material may continue, and other dreams, memories, flashbacks, feelings, etc. may emerge.

I have been advised to check with my medical physician before beginning ***ART*** treatment concerning any medical conditions which might put me at risk due to the possibility of a heightened emotional reaction or neurological conditions (like epilepsy) from ***ART*** treatment. It is recommended to refrain from as needed medication that causes sleepiness prior to an ***ART*** session.

Before commencing ***ART*** treatment, I have thoroughly considered all of the above. I have obtained whatever additional input and/or professional advice deemed necessary or appropriate to have ***ART*** treatment, and by my signature below I hereby consent to receive ***ART*** treatment. My signature on the acknowledgement and consent is free from pressure or influence from any person or entity.

I have read and understand the information presented in this form. I consent to receive treatment ***ART*** Treatment. If you are signing on behalf of your dependent, please print his/her name, and your relationship to the client. I understand that I have the right to terminate treatment or refuse treatment at any time; I will give notice of my intent to terminate.

_____
Client Signature

Date: _____

_____
Parent/Guardian

Date: _____

_____
Witness

Date: _____