

## **EMDRIA Remote or Direct Individual C.I.T. Consultation Agreement**

This agreement is made between Matthew Ackenhausen (an EMDRIA Approved consultant—referred to in this agreement as “Consultant”) and \_\_\_\_\_ (consultee/C.I.T.). Consultant agrees to provide Consultee with clinical case consultation in the use of EMDR therapy consistent with EMDRIA’s standards for consultation toward the designation of EMDRIA-Approved Consultant in EMDR therapy.

**Nature of service:** Consultee is seeking consultation services to increase Consultee’s skills in the use of EMDR therapy. In addition, Consultee request Consultant to evaluate Consultee’s fidelity in application of EMDR therapy methods and procedures. Specific learning objectives include perceptual, conceptual, and functional skills with the theoretical, practical, and technical application of EMDR as a method of psychotherapy. EMDR therapy case formulation and treatment planning skills will also be addressed. Screening procedures and issues of differential diagnosis for individuals with personality or dissociation disorders may also be addressed; however, Consultee agrees that modified EMDR treatment procedures or protocols for applying EMDR treatment to those with dissociative disorders will not be addressed and will not be included under the scope of this agreement.

**Limits of service:** It is expressly understood that no supervision or employment relationship exist between Consultant and Consultee. Consultee affirms that he or she is independently licensed or credentialed to practice psychotherapy in his or her jurisdiction, maintains professional liability insurance, and that Consultee remains solely responsible for the nature and quality of the services provided to Consultee’s clients. Consultant agrees to provide Consultee information based on available research, scholarly consensus, and Consultant’s experience for Consultee to consider. At all times, Consultee will rely on his or her own judgement and discretion in offering psychotherapy services to Consultee’s clients. Consistent with the professional standards of Consultee’s licensure or certification, jurisdiction, and professional memberships, Consultee will obtain separate, additional consultation from another consultant(s) for any significant clinical, ethical, legal, or professional issues which merit it.

(Alternate **Limits of service** language when Consultee is working under legally required supervision as a pre-licensed clinician: It is expressly understood that no supervision or employment relationship exist between Consultant and Consultee. Consultee acknowledges not being independently licensed or credentialed to practice psychotherapy in his or her jurisdiction. Consultee is providing psychotherapy services under the legally required supervision of \_\_\_\_\_ (referred to as Supervisor). In signing below, Supervisor acknowledges that Supervisor remains solely responsible for the nature and quality of the services provided to Consultee’s clients. Consultee agrees to review information received from Consultant during case discussions with Supervisor. Both Consultee and Supervisor affirm that they are covered by professional liability insurance. Consultant agrees to provide Consultee information based on available research, scholarly consensus, and Consultant’s experience for Consultee to consider. At all times, Consultee will work closely with Supervisor and rely on Supervisor’s judgement and discretion in offering psychotherapy services to Consultee’s clients. When significant clinical, ethical, legal, or professional issues arise which merit it. Consultee and/or Supervisor will obtain additional consultation from another consultant in accord with the professional standards of Consultee’s internship requirements and Supervisor’s licensure or certification, jurisdiction, and professional memberships).

**Confidentiality:** Consultee will notify his or her clients and obtain written informed consent naming both Consultant and Consultee prior to presenting any confidential case material to Consultant. Consultee agrees not to disclose any identifying information to Consultant and to take steps to alter or omit any potentially identifying information from case material being presented orally, in writing, or in audio or video recordings.

**Evidence of fidelity in the use of EMDR Therapy:** To assist Consultant in evaluating Consultee’s knowledge and skill, Consultee will provide Consultant with behavioral work samples from actual clinical sessions. These can be in the form of audio or video recordings or near-verbatim transcripts. One or more work samples must demonstrate satisfactory fidelity to standard EMDR therapy principles, procedures, and protocols. More than one review may be needed to provide satisfactory fidelity. Consultee will present at least one behavioral work sample to Consultant by the fifth hour of consultation. If Consultant identifies significant issues that would prevent Consultant from being able to recommend

Consultee for: *EMDRIA-Approved Consultant, EMDRIA-Certified, EMDRIA-Basic I & II Clinician* in EMDR therapy, Consultant will notify Consultee as soon as possible. Consultant will then recommend possible corrective actions to Consultee. Consultee expressly gives permission for Consultant to present verbal and written summaries of their consultation sessions to Consultant and to review all behavioral work samples with Consultant. Consultee expressly gives permission to Consultant to provide a copy to Consultant of this agreement and all correspondence with EMDRIA regarding Consultee.

**Records and correspondence:** Consultant will maintain a record of hours of consultation completed by Consultee. Consultee will maintain completed release of information forms in each individual case file authorizing Consultee to release information to Consultant and Consultant. Consultee agrees that Consultant will submit a letter to EMDRIA describing the number of hours of consultation Consultant has provided when Consultee either completes required hours of consultation or discontinues consultation. Consultee may discontinue session at any time with the understanding that Consultant will submit a letter to EMDRIA documenting number of hours of consultation completed. If the Consultee discontinues consultation with significant issues identified by the Consultant that remain unresolved, Consultant will describe these issues in correspondence to EMDRIA along with Consultant's suggestions for corrective action. If Consultee has completed required hours of consultation and provided evidence of satisfactory knowledge and skills in the application of EMDR therapy, then Consultant will write a letter recommending Consultee for the designation of *EMDRIA-Approved Consultant, EMDRIA-Certified, EMDRIA-Basic I & II Clinician* in EMDR therapy.

**Resolution of issues:** Consultant and Consultee agree to follow their respective professional organizations' code of ethics. If any professional or ethical issues arise related to the consultation relationship, Consultant and Consultee will make every effort to resolve them informally and with good will.

**Logistics:** Contact to schedule dates and times for appointments.

**Fees:** Consultee will pay Consultant a fee of \$ \_\_\_\_\_ per hour of service for consultation. If consultee requests Consultant to review work samples, such as videotapes or audiotapes, without Consultee in attendance, Consultee agrees to pay a fee of \$ \_\_\_\_\_ per hour for review of work samples. Hours of consultation time may be counted for review of work samples only when both Consultee and Consultant are present. Consultee or Consultant will give at least 48 hours' notice of cancellation of scheduled sessions.

Consultant  
Signed: \_\_\_\_\_  
Name: \_\_\_\_\_  
Date: \_\_\_\_\_

Consultee  
Signed: \_\_\_\_\_  
Name: \_\_\_\_\_  
Date: \_\_\_\_\_

(Name and signature below are only needed if Consultee is working under supervision.)

Supervisor  
Signed: \_\_\_\_\_  
Name: \_\_\_\_\_  
Date: \_\_\_\_\_



# Payment Information

\_\_\_ I agree to pay \$ \_\_\_ for this individual consultation session in full in advance by check # \_\_\_\_.

Or \_\_\_ I authorize Matthew Ackenhausen, LCSW to charge my credit card below for automatic payments of \$ \_\_\_ each session.

Credit Card Information Check one:  MasterCard  Visa  Discover  American Express Card number: \_\_\_\_\_ Expires \_\_\_\_\_ 3 or 4 digit Security Code \_\_\_\_\_

Name on card: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ Credit Card Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_ -----  
----- Contact Information

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_  
\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_ Please print legibly.

By signing below, I indicate my acceptance of this Group Consultation Agreement:

Print Name: \_\_\_\_\_ Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Matthew Ackenhausen, LCSW, 5215 E. 71<sup>st</sup> Street; Suite 1600, Tulsa, Ok 74136 Phone: (918) 282-3654



Matthew Ackenhausen, LCSW