Contractual Agreement for

DBT for High Conflict and Avoidant Couples

St Louis DBT, LLC
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Partner/Spouse _____

Email _____ **Cell** _____

Partner/Spouse _____

Email _____ **Cell** _____

St Louis DBT Commitments

_____ _____ St Louis DBT commits to provide an evidence-based 12 week skills group that includes an optimal balance of instruction, practice exercises and discussion. The skills group is not intended to be a therapy group.

_____ _____ St Louis DBT strives to provide an experienced DBT therapist to work with each couple. Each therapist will observe and coach a couple to apply skills effectively. Therapists commit to clinical neutrality between partners.

_____ _____ Therapists commit to respond to phone calls, texts and emails for coaching seven days a week between the hours of 7:30 am and 9:30 pm. Coaching contacts are intended to be no more than 10-15 minutes in length and focus on identifying skills participants can use to address an immediate need. Couples are strongly encouraged to contact the therapist jointly (e.g., speaker phone, group text or cc email). Partners should be aware that DBT therapists have a policy of not keeping secrets between partners.

_____ _____ Out-of-class couples sessions are available on an as needed basis to address difficult issues that arise in class. The couple may request or therapist may suggest a couples session. Couples sessions will be made available at a discounted rate. The discounted rate will only be made available during the weeks in which sessions are scheduled.

Couples Commitments

Both partners initial each provision to indicate you have read and agree to the following commitments.

_____ _____ We commit to attend all 13 sessions. We understand there are only three couples in the skills group and that any absence affects the quality of other participants' experience.

_____ _____ We commit to do assigned homework between sessions. Homework may require 4-6 hours per week. We understand that without practice progress will not occur.

_____ _____ We understand that in-class practice exercises may on occasion cause emotional discomfort. We understand DBT therapists will do all in their power to minimize emotional discomfort but understand that some discomfort is necessary to make progress.

_____ _____ We agree that during the DBT Couples Skills Group we will not threaten, discuss or move forward with divorce proceedings. For the duration of the skills group, we commit to work wholeheartedly toward developing the skills needed to increase harmony and closeness in our relationship.

_____ _____ We certify there has been no physical or sexual violence occurring between us in the past six months.

_____ _____ If applicable, we certify that other mental health providers I/we see are aware of my/our intent to participate in Couples DBT and we have their support for participation. I/we understand that the need may arise to consult with other providers and agree to sign a confidentiality release.

_____ _____ If under psychiatric care, I/we commit to continue under care and follow treatment recommendations throughout the duration of the skills group.

_____ _____ I _____ give St. Louis DBT, LLC permission to bill my credit or debit card $110/week for 13 sessions (12 group sessions plus one private session), ***including absences and cancellations for any reason.*** We understand no exceptions will be made.

_____ ____ We understand 13 sessions will include 10 consecutive sessions, a two week break with homework, followed by two consecutive weeks. The break allows couples to practice the skills on their own, followed by two classes that will focus on the most challenging skills. The thirteenth private session will be scheduled at the mutual convenience of therapist and couple to do an analysis of problem behaviors unique to the clients.

_____ I _____ agree that the credit card listed on this form may be charged per session at the above agreed upon rate. I will be provided an itemized receipt that may be kept for my records and/or submitted to my insurance company for out-of-network reimbursement.

_____ ____ We agree _____ should be listed as the designated client for insurance purposes and the diagnosis should be listed as _____

_____ I [ ] do or [ ] do not authorize the therapist to email a monthly service receipt. If authorized, send it to this email address _____

_____ _____ _____ _____

Number on credit card to be charged | Expiration Date | Sec Code | Card Type

_____

Full Billing Address

_____

Printed name as it appears on credit card

.

Signature _____ **Date** _____

Signature _____ **Date** _____

Therapist's Signature _____ **Date** _____