<u>EMDR Advanced Remote Group Consultation Agreement</u>

This is a consultation contract between Andrew M. Leeds, Ph.D., EMDRIA Approved Consultant, and ________________________________ referred to as "I" or "Consultee".

<u>Objective</u>: The objective of this consultation group is to increase clinicians' knowledge and skills in the use of EMDR therapy for clients where there are complex clinical issues of structural dissociation, affect phobias, psychological defenses, personality disorders or co-occurring disorders.

<u>Eligibility</u>: clinicians with at least six months of EMDR practice after completing an EMDRIA approved basic training in EMDR therapy.

____ [Initial here] <u>Limits of Service</u>: It is expressly agreed that no supervision or employment relationship exists between Consultant and Consultee. Consultee – or Consultee's legally mandated supervisor if any – remains solely responsible for services provided to Consultee's clients. Consultant will provide information based on research, scholarly consensus, and Consultant's experience for Consultee to consider. ***Consultee will rely on his or her own judgment in offering specific psychotherapy services to Consultee's clients and will not state or imply he or she is following guidance from Consultant.***

<u>Not for EMDRIA Consultation hours</u>: It is expressly understood that the consultation offered through this agreement is for advanced EMDR clinicians and is not structured to meet the requirements for EMDRIA Certification in EMDR. Consultee understands and agrees that hours of consultation provided under this agreement will not be applicable to EMDRIA Certification.

<u>Conflict resolution</u>: A friendly atmosphere is advocated and fostered in the consultation process. If differences arise, both Dr. Leeds and I commit to resolving any issues in a professional and mutually beneficial manner, including, if necessary, bringing in a third party. Dr. Leeds and I each agree to abide by the code of ethics of the professional organization(s) to which we belong.

<u>Logistics</u>: The consultation group will meet via Zoom for 6 sessions

Friday Series: Apr 10, May 8, July 10, Aug 14, Sept 11, Oct 16, 2026.

Call times for the Friday series: Pacific: 11:00 am – 1:00 pm;
Mountain: 12:00 noon – 2:00 pm; Central: 1:00 pm – 3:00 pm; Eastern: 2:00 pm – 4:00 pm

The consultation group includes a maximum of eight members. I will be given in advance a series of Zoom meeting invitations that allow options for access by the Zoom application or telephone. I agree to securely share case files via a free account on Box.com.

____ [Initial here] To keep consultation fees ***reasonable, I understand I will not be given an alternate session nor a refund if I am unable to attend one or more of the sessions*** for which I am registered.

<u>Confidentiality</u>:
____ [Initial here] As a member of this consultation group, ***I agree to notify clients and obtain their written consent to my seeking consultation without specifically identifying the name of my consultant***. I will alter identifying information in any case material I present. I will treat as confidential all case material presented by others in this group.

<u>Work samples</u>:
When possible, I will provide written case summaries and/or near verbatim transcript of reprocessing sessions when presenting individual cases. A case summary form and near verbatim summary guide is available from Dr. Leeds website Resources page at: <u>https://www.emdrconsultation.net/resources</u>

____ [Initial here] I agree to pay the consultation group fee in full as described below even if I miss one or more of the sessions. ***No make-up sessions are provided. Switching group series is not permitted.***

I am confirming my choice of day and dates by initialing below for the Advanced Friday Series and checking my choice of fee arrangements below:

Friday Series: Apr 10, May 8, July 10, Aug 14, Sept 11, Oct 16, 2026. 5

Standard fee ________

___ I agree to pay $510 for this consultation group series in full in advance by check #_____.

Or

___ I authorize Dr. Leeds to charge my credit card below for six automatic payments of $90 each month the week of each session as listed above for a total of $540.

Agency discount

___ Initial here to request the 25% fee reduction available to clinicians employed in Community Mental Health or nonprofit agencies. ***With this signed agreement include a letter on agency letterhead confirming employment 30 hours or more per week.***

___ I agree to pay $384 for this consultation group series in full in advance, by check #_____.

Or

___ I authorize Dr. Leeds to charge my credit card $68 per month for a total of $408.

Forms can also be securely uploaded at **https://tinyurl.com/consultformupload**

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:_________

Andrew M. Leeds, Ph.D., 1049 Fourth St., Suite G, Santa Rosa, CA 95404
info@AndrewLeeds.net Phone: (707) 579-9457 Fax: (707) 703-5334

You can sign this form digitally with the free Adobe Acrobat DC.