

## EMDRIA Remote Group Consultation Agreement

This is a consultation contract between Andrew M. Leeds, Ph.D., EMDRIA Approved Consultant, and \_\_\_\_\_ referred to as “I” or “Consultee”.

**Objective:** The main objective of this group is to increase Consultee’s skills in the use of EMDR therapy. Specific learning objectives include perceptual, conceptual and procedural skills. The primary body of controlled treatment outcome research addresses the use of EMDR therapy for Posttraumatic Stress Disorder, Specific Phobias and other trauma related clinical syndromes. The group focus will be on standard EMDR procedures described in Francine Shapiro’s latest text and Andrew M. Leeds’s 2016 text. *Screening procedures and issues of differential diagnosis for dissociative and personality disorders* may be addressed; however, to meet EMDRIA community standards for hours toward Certification, Consultee agrees that **modified EMDR treatment protocols** required for applying EMDR treatment to those with dissociative or personality disorders will not be addressed.

**Limits of Service:** 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 at all times rely on his or her own judgment in offering specific psychotherapy services to Consultee’s clients.

**EMDRIA Group and Individual Consultation hours:** After the 6<sup>th</sup> group session, Dr. Leeds will provide documentation of consultation hours for the time I spend in these sessions. I will receive credit for individual consultation hours when I present and discuss my case material on the use of EMDR therapy for at least 20 minutes. I will announce myself when I enter and before leaving a conference call.

**Conflict resolution:** A friendly atmosphere is advocated and fostered in the consultation process. If differences arise, both Dr. Leeds and I commit ourselves to resolve 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.

**Logistics:** The consultation group will meet via teleconference call for 6 sessions.

**Friday Series:** January 3, January 31, March 6, April 3, May 1, and June 12, 2020

Call times for the Friday series: Pacific: 9:00 AM – 11:00 AM; Mountain: 10:00 AM – 12:00 Noon; Central: 11:00 AM – 1:00 PM; Eastern: 12:00 Noon – 2:00 PM

The consultation group includes a maximum of eight members. I will be given in advance via e-mail the conference phone number and pin and options for web browser and app login. I understand I am responsible for any long distance charges. The call is to a US domestic phone number with alternate numbers in many other countries. I agree to securely share case files via a free account on Box.com.

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.

### Confidentiality:

As a member of this consultation group, I agree to notify my clients and obtain their written consent in advance of presenting case material. I will treat as confidential any case material presented by others in this group. Although not required, when possible, I will provide a written case summary and/or near verbatim transcript of reprocessing sessions to Dr. Leeds and other members of this group when presenting individual cases. I will alter identifying information in any case material I present.

A case summary form and near verbatim summary guide is available from Dr. Leeds website Resources page at: <https://www.emdrconsultation.net/resources>

**Fee:** 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 and switching of group series is not permitted.**

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

**Friday Series:** January 3, January 31, March 6, April 3, May 1, and June 12, 2020

<u>Standard fee</u>
___ I agree to pay \$420 for this consultation group series in full in advance by check # ____.
<b>Or</b>
___ I authorize Dr. Leeds to charge my credit card below for six automatic payments of \$75 each month the week of each session as listed above for a total of \$450.

<u>Agency discount</u>
___ Initial here to request the 25% fee reduction available to clinicians employed in Community Mental Health or nonprofit agencies. <b>With this signed agreement include a letter on agency letterhead confirming employment 30 hours or more per week.</b>
___ I agree to pay \$315 for this consultation group series in full in advance, by check # ____.
<b>Or</b>
___ I authorize Dr. Leeds to charge my credit card \$56.25 per month for a total of \$337.50.

**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: \_\_\_\_\_

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**Contact Information**

**Mailing Address:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Please print legibly.**

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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**  
**Phone: (707) 579-9457, Fax: (707) 703-5334**