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: Group objective is to increase Consultees' perceptual, conceptual and procedural skills in EMDR therapy. Group focus will be on standard EMDR procedures described in Francine Shapiro's 2018 text and Andrew M. Leeds's 2016 text. *Screening procedures and differential diagnosis for dissociative and personality disorders* may be addressed. However, to meet EMDRIA standards for hours toward Certification, Consultee agrees that ***modified EMDR treatment protocols*** required for EMDR treatment of those with dissociative or personality disorders will not be addressed.

____ [Initial here] 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 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.***

EMDRIA Group Consultation hours only: This group is structured to provide only group consultation hours toward EMDRIA Certification***. I will actively share my EMDR case work experience in each session***. After the 6th group session, Dr. Leeds will provide documentation of group consultation hours for the time I spend in these sessions.

Conflict resolution: 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.

Logistics: The consultation group will meet via Zoom for 6 sessions

Saturday Series: September 14, October 12, November 9, December 14, 2024, January 11, February 8, 2025

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

Confidentiality:
____ [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.

Work samples:
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: https://www.emdrconsultation.net/resources

____ [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 confirm and accept the dates below for the Saturday Series by checking my choice of fee arrangements:

Saturday Series: September 14, October 12, November 9, December 14, 2024, January 11, February 8, 2025

Standard fee _____

___ I agree to pay $480 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 $85 each month the week of each session as listed above for a total of $510.

Agency discount

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

___ I agree to pay $360 for this consultation group series in full in advance, by check.

Or

___ I authorize Dr. Leeds to charge my credit card $64 per month for a total of $384.

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.

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