Kristi DuCote, MA, LPC, LCDC
469.688.1787

101 S. Fannin St., Ste. 105, Rockwall, TX 75087

CONSENT FOR (EMDR): EYE MOVEMENT DESENSITIZATION AND REPROCESSING

Client Name:_____Date:_____

Eye Movement Desensitization and Reprocessing (EMDR) methodology is a form of adaptive information processing which may help the brain unblock maladaptive material. It also appears that EMDR may avoid some of the long and difficult emotional work often involved in the treatment of anxiety, panic attack, post- traumatic stress symptoms (such as intrusive thoughts, nightmares, and flashbacks), dissociative disorders, depression, phobias, identity crisis and other traumatic experiences.

Please be advised of the following:

1) Distressing, unresolved memories might surface through the use of the EMDR procedure.
2) Some patients have experienced reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotion or physical sensations.
3) The processing of incidents/material may continue and other dreams, memories, flashbacks, feelings, etc. may surface between sessions. Due to this unforeseen phenomenon it is recommended that you refrain from leaving treatment against medical advice.
4) Those with limiting or special medical conditions (pregnancy, heart condition, ocular difficulties, history of seizures, etc.) should consult their medical professionals before participating in this therapeutic method. Please notify your therapist if you have a history of dissociative disorder.
5) For some patients, this method may result in sharper memory, for others, fuzzier memory. If you are involved in a legal case and need to testify, please discuss this with your therapist.
6) For training purposes, I allow my therapist at times to record my session/discuss details of my case to assist in the fidelity of the EMDR modality. _____

Before commencing EMDR treatment, I have thoroughly considered all of the above. I have obtained whatever additional input and/or professional advice that I deemed necessary or appropriate. By my signature below, I thereby consent to receiving EMDR treatment. My signature acknowledges that this consent form was presented with no pressure or influence from any person or entity.

_____ _____

Client Signature Date Client Name (Printed) D.O.B

_____

Kristi DuCote, MA, LPC, LCDC