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CONSENT TO TREATMENT WITH RAPID RESOLUTION THERAPY

Rapid Resolution Therapy (RRT) <http://www.rapidresolutiontherapy.com> is a therapeutic modality that combines concepts of cognitive therapy such as education and cognitive restructuring with elements of hypnosis.

The goal of RRT is to clear patients' problems in a painless and effortless way. While patients can be asked to recount painful experiences the technique seeks to avoid painful relieving and abreaction. However, as with all therapy, it is possible that emotional distress and others negative side effect identified in the "Office Policies and Consent to Treatment" may ensue.

Hypnosis is a safe modality when used appropriately, but again emotional distress and other negative side effects can ensue, as above.

Of note, material recalled while using hypnosis may not be "objectively true," it may reflect internal representations, conflicts, information garnered elsewhere.... or be in any other way distorted. Any "memory" discussed during a session is addressed for the purpose of therapeutic healing, it is not meant in any way to ascertain facts.

While patients are typically alert throughout the RRT session, if you were to experience any drowsiness, do not drive until once again alert.

Given that RRT and hypnosis can be effective in treating pain, and therefore mask a medical condition, before treating pain I will need the permission of your treating physician to do so. You can bring in a written statement or hereby grant me permission to discuss treatment with your physician. This will not be necessary in the case of phantom pain, given the nature of the complaint.

Important: if you are involved, or may become involved in a legal dispute, be aware that a court may not allow your testimony if you had any treatment involving hypnosis. This could compromise your case.

I understand the information above, including that regarding any legal dispute, and consent to treatment using RRT.

Print Name and Date

Signature and Date

I give permission to Dr. Long to discuss my treatment with my doctor

Name and ph N. of MD _____

Signature and Date