

Integrative Psychotherapy Training Program of Kansas City

4104 Central Street
Kansas City, Missouri 64111
Phone: 816-753-1110

Trainers:

Jude Lilienthal, LSCSW, LCSW ~ Peg Marland, LPC ~ Shelley Stelmach-Nigro, LPC

CONTRACT 2023-2024

Jude Lilienthal, Peg Marland and Shelley Stelmach-Nigro agree to lead the Training Program. The Training Program will meet at 4104 Central Street, Kansas City, Missouri 64111.

The Program consists of nine (9) six (6) hour weekend workshops that will convene on Saturdays from 9:30 a.m. – 12:30 p.m. and from 2:00 p.m. – 5:00 p.m.

The total cost for the program will be One Thousand Three Hundred Fifty Dollars (\$1350.00). Please choose from the following payment options by **initialing** on the line provided. Make checks payable to **Shelley Stelmach-Nigro**.

_____ I will pay nine monthly payments of \$150.00 due at the first of every month
initials starting September 2023 through May 2024.

_____ I wish to make other arrangements for payment with Shelley
initials Stelmach-Nigro.

Initials _____

Participation in the Training Program is voluntary and you may withdraw from it at any time. If your withdrawal is related to thoughts of harm to yourself or others the leaders may be obligated to inform your therapist or proper authorities of the reasons for your withdrawal.

Signing this contract constitutes a financial commitment for the entire year. The sessions will be held either in person or via Zoom, in accordance with the CDC guidelines. In the event of bad weather, to be determined and communicated by the trainers, the session(s) will be held via Zoom. Non-attendance or non-completion of training for the contract period is not a valid reason for nonpayment of any part of the training fee. The training fee is non-refundable.

You are not obligated to participate in the Training Program by sharing information with the Training Group that you want to remain confidential between yourself and the trainers and co-trainers. If you want information to remain confidential so that only your therapist and you know the information you should not reveal that information in the Training Group.

The Training Program is not to be construed as a therapy group. However, a portion of the training is experiential in nature so all trainees will be expected to be engaged in working on their own personal process in the group setting. At times this will involve one of your peers acting in the role of the therapist for your piece of work. This will only occur under the immediate supervision of a trainer. In this way each trainee is afforded the opportunity to receive direct supervision while deepening their therapeutic skills. There are risks involved in psychotherapy and as either client or therapist you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness or helplessness. While we will be attentive to helping you come to a place of safety in any piece of personal work you engage in, it should be understood that the emphasis will be placed on the trainee who is acting as therapist receiving a positive learning experience. It is therefore a requirement of the Training Program that each participant be in his/her private therapy. We will require you to consent for us to communicate with your primary therapist and for your primary therapist to communicate with us.

If any issues or concerns arise for you regarding your participation or progress in the training program, you are strongly encouraged to bring your concerns to the attention of the leaders and we will make every effort to effectively address your needs.

The Training Program does not automatically fulfill requirements for licensure and does not constitute legal supervision. Practicing counseling, psychology, or social work without a license is prohibited under the law in the state of Missouri. If you are not licensed or in the process of becoming licensed, your acceptance into the Training Program can in no way be construed as the trainers' condoning your seeing clients.

Initials _____

Please return this signed and dated contract. Your signature that follows and initials at the bottom of each page are verification that you understand, agree, and intend to comply with this contract.

Your Signature

Date

Print Name

Please provide the following information:

Address

City/State/Zip

(____)_____
Home Phone

(____)_____
Work Phone

(____)_____
Cell Phone

Email Address

Emergency Contact name

Emergency Contact Phone

Leaders' signatures:

Jude Lilienthal, LSCSW, LCSW

Date

Peg Marland, LPC

Date

Shelley Stelmach-Nigro, LPC

Date

Initials _____

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CONFIDENTIALITY AGREEMENT

In any therapeutic setting, confidentiality is of paramount importance. When any one of us shares or works in either phase group, large group or small group, the content of the sharing must remain confidential. This means, for instance, that work that has happened in a small group should not be talked about by members of that small group with anyone including others in the program. The trainers and co-trainers will have access to information from all groups.

We're asking that you sign this sheet as a statement that you have read our confidentiality policy, understand it, and are willing to adhere to it.

Your Signature

Date

Initials _____