In/Sight Stress Reduction
Informed Consent

I consent to participate in an 8-session group program patterned after Mindfulness-Based Stress Reduction with an emphasis on the learning and practice of mindfulness-based meditation. I understand that this group is facilitated by licensed health/mental health professionals. I understand that I am expected to attend each of the eight weekly sessions and to practice the home assignments to the best of my abilities.

Participation in this program will include the completion of questionnaires prior to and after completion. These questionnaires will be treated as strictly confidential and will be used for research and/or program development purposes.

The goal of the program is to provide the fundamentals of stress reduction:

- Group support
- Information for the purposes of identifying and reducing physical and emotional stress, as well as pain management
- The practice of meditation as a method of eliciting the natural relaxation response, strengthening the immune system, and learning to cope with stress in positive life enhancing ways

I understand that stress reduction in this program is based on the identification of specific stressors in my life, their effects on my functioning, and the learning of more positive healthy ways of eliminating or managing those stressors. I understand that there is a psychological risk involved in my participation. This may lead to anxiety as issues are discussed in the group and meditation is practiced. Some of these issues may be uncomfortable to experience.

I understand that the program includes skill training in relaxation and meditation methods as well as gentle Tai Chi-type movements. During the program I will be asked to practice these appropriate to my abilities. I understand that if for any reason I am unable to, or think it unwise to engage in these techniques and exercises during the weekly sessions or at home, I am under no obligation to do so.

I understand that my confidentiality will be maintained at all times during and after this program by the facilitators. I may choose to allow the facilitators to coordinate my treatment with my primary health care provider and/or therapist.

Signature_____ Date_____

Printed Name_____