SILVER LINING
COUNSELLING SERVICES

Consent for Treatment

_____ _____
Client's Name **Date of Birth**

_____ _____
Client's Name **Date of Birth**

Gender: Male ☐ Female ☐ Other _____

Marital Status: Never Married ☐ Domestic Partner ☐ Married ☐

Divorced/Separated ☐ Widowed ☐

Address :_____

Home Phone: (_____) _____-_____ **Cell/Other Phone:** (_____) _____-_____

May We Leave a Message? Yes ☐ No ☐ May We Leave a Message?: Yes ☐ No ☐

Email: _____

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation: _____ **Place of Employment:** _____

Work Number: (_____) _____-_____

If needed, is it OK to call here? Yes ☐ No ☐

Emergency Contact:

Name:_____ Relationship:_____

Phone Number: (_____) _____-_____

How were you referred to Silver Lining Counselling Services?

☐ Friend/Family ☐ Therapist ☐ Physician ☐ Internet ☐ Other (please specify)_____

_____
Referral Name Relationship to Client

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Consent for Treatment

I consent to assessment, treatment, and/or diagnostic procedures for myself or for my family member. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I agree to pay my bill for services in full. I understand that my insurance company may not cover my sessions and that it is my responsibility to arrange coverage of my sessions through my insurance provider. I authorize the release and exchange of information between my therapist and the referral source and other co-treating providers for the purpose of treatment, payment, and health care operations. I authorize the release of information to my health plan for claims or health plan purposes.

Client Signature **Date**

Client /Guardian Signature **Date**

Witness **Date**

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Intake Information

Have you previously received any type of mental health services? Yes ☐ No ☐

If yes, which of the following: Psychotherapy ☐ Medication ☐ Outpatient Hospitalizations ☐

Inpatient Hospitalization ☐

If yes, please provide:

Name of provider or facility:_____

Location:_____

Dates of treatment:_____

Reason for treatment:_____

Briefly, what brings you in today? _____

_____

When did your problem first start? Within the last:

☐ 30 days

☐ 6-12 months

☐ 2 years

☐ During adolescence

☐ During childhood

What areas of your life have been affected because of this problem?

_____

What would you like to accomplish out of your time in therapy?

_____

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice describes policies related to the use of your records while you are under the care of Silver Lining Counselling Services. We are required to give you this Notice about: **1) the use or disclosure of your health information; 2) our legal responsibility; and 3) your rights concerning your health information.**

1. Use and Disclosure of Protected Health Information
Silver Lining Counselling Services use and disclose the minimum necessary health information about you for your treatment and for payment of services.

a. We consult regularly with a supervisor and consultation group comprised of other therapists. The information is kept strictly confidential and may not be revealed to anyone outside the group.

b. We may use and disclose your health information to obtain payment for services we provide to you. For example, we may need to give insurance companies or other agencies the minimum necessary information in order for them to reimburse you for the service we have provided to you.

2. Information Disclosed Without Your Consent
Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Information about you may be disclosed without your consent in the following circumstances.

a. **Emergencies.** Sufficient information may be shared to address an immediate emergency you are facing.
b. **Judicial and Administrative Proceedings.** We may disclose your personal health information in the course of a judicial or administrative proceeding in response to a valid court order or other lawful processes, including if you were to make a claim for Workers Compensation.
c. **Public Health Activities.** If we feel you are an immediate danger to yourself or others, we may disclose health information about you to the authorities, as well as alert any person who may be in danger.
d. **Child/Elder Abuse**. We may disclose health information about you related to the suspicion of child and/or elder abuse or neglect.
e. **Criminal Activity or Danger to Others.** We may disclose health information if a crime is committed on our premises or against our personnel, or if we believe there is someone who is in immediate danger.
f. **Scheduling Appointments**. If you have given permission, we may use your phone number to call you and leave messages to schedule or remind you of an appointment. Similarly, if you have given permission, we may send you an email to schedule or remind you of an appointment.

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Office Policies

Confidentiality
All information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances: when there is a reasonable suspicion of child abuse or neglect, or abuse to a dependent or elder adult; when the client presents an imminent danger to self; when the client presents an imminent danger to others; if a judge determines that our discussions are not confidential. If the client is a minor, you acknowledge that your child's records are confidential except in the above-stated exceptions.

Phone & Emergency Contact
If you need to contact us by phone, do not hesitate to call the office number. If we are not available, you can leave a message on our voicemail and we will usually return the call that day. If your situation is an emergency, please call 911 or go to your nearest emergency room. Email communication should only be used for scheduling with your therapist. If you communicate confidential information via email or text we will assume that you understand that it is vulnerable to not remaining private. Please do not use texts, emails or voice mails for emergencies.

Therapy Process and Termination
Psychotherapy can result in a number of benefits to you. Yet you are free to terminate therapy at any time. We can provide you with referrals to other therapists at your request. We do not perform custody evaluations and do not make recommendations regarding custody. We also do not prescribe medication or make recommendations about medication, but will refer you to a psychiatrist if you believe you are in need of a medication evaluation.

You are responsible for paying your portion of services provided in a timely manner. In the event of nonpayment, if Silver Lining Counselling Services is reduced to taking legal action to collect payment, you are responsible for paying reasonable collections and attorney fees

Cancellation of Appointment
The scheduling of an appointment involves the reservation of time, specifically for you. In the event of a "No Show" or failure to give one business day notice of a cancellation, you will be charged the full session fee for all late cancellations and missed appointments.

***By initialing here, you acknowledge the Cancellation Policy.** _____

_____ _____
Client Signature **Date**

_____ _____
Client Signature/Guardian **Date**