CONSENT OF TREATMENT/CONFIDENTIALITY STATEMENT

Welcome! Congratulations on your decision to enter into counseling. I offer counseling, assessment, crisis intervention, case management and social services for infants, children, adolescents, families, and adults. These services are provided through individual, family, couples, group formats. I want to be sure that you understand the nature of the services that you are receiving. Please read the information below and to sign and date this form.

I, ____, hereby make request for myself, or my minor child, ____, to receive care and treatment voluntarily from Elizabeth Crenshaw, Marriage and Family Therapist, MFT#32000. I understand that such care and treatment may consist of an evaluation process, counseling, and case management.

Elizabeth Crenshaw, MFT, is hereby authorized to provide the treatment/services described above if this request is accepted. Such consent, however, does not waive my civil rights; I reserve the right to decline treatment against the advice of my clinician at any time. I agree that counseling is a cooperative effort between my therapist and myself, and I agree to work with my therapist collaboratively to resolve my difficulties.

I further understand that my records are considered confidential pursuant to W&I 5328 and will not be released to outside individuals or agencies without my express written consent. However, I realize that certain information may be released without my authorization under specific circumstances including, but not limited to, the following:

1. Suspected child physical and/or emotional abuse and dependent adult or elder abuse must be reported to the authorities immediately. This may include sexual contact between an adult and a child.
2. If a client implies a serious threat of violence or danger to a person or his/her property, the clinician is bound by duty to forewarn that person and to notify the authorities (police).
3. A therapist may provide reasonable protective care to a suicidal client, under certain circumstances.
4. Counseling records may be subpoenaed by a court of law, under certain specific circumstances.
5. A release of information is signed by the client to authorize the counselor to obtain and exchange Information with outside individuals/agencies relevant to treatment.
6. When otherwise required by law or if your insurance company mandates a release of information for audits, appeals, reviews, etc.

Payment is due at the time of the session unless other arrangements have been made. The fee for each 50 minute session is $________.

☐ I am aware that I will be billed for a session that is canceled less than 24 hours notice or if no notice is given. Messages may be left 24 hours a day at (707) 775-9895, Santa Rosa office.

☐ I am authorized to consent of treatment. I have read the above and I agree to accept treatment for myself or my child and I further agree to all conditions set forth herein. I acknowledge that I have received a copy of this agreement. I understand that if necessary, I can contact a 24 hour emergency crisis number at 1 (800) 309-2131.

____ ________________________
Client/ Parent or Guardian Signature Date

____ ________________________
Client/ Parent or Guardian Signature Date

____ ________________________
Minor's signature (optional) Date

____ ________________________
Witness/Clinician's signature Date