Joan Forest LICSW 360-969-5583 791 SE Fidalgo Ave #101 Oak Harbor, WA 98277

Treatment Consent and Authorization

I, _____, authorize Joan Forest LICSW to assess, diagnose and create a treatment plan with me based on the issues presented. I have been made aware of the following rules, rights and responsibilities and agree to enter into a fee for service contract.

CANCELLATION/NO SHOW POLICY:

I agree to contact Joan Forest LICSW 24 hours prior to appointment to reschedule or I agree to pay the $40 no show fee that will be collected at the next date of service. _____ Initial

Joan Forest LICSW keeps a record of the services provided to you. As a matter of general practice, information revealed by you during therapy will be kept confidential and will not be released to any other person or agency without your written permission. Certain situations exist however, in which we are required by law to reveal information shared during treatment without your permission. These situations include but are not limited to instances when you threaten grave bodily harm or death to yourself or another person or persons; where you disclose abuse or neglect of a minor or an elderly person; where a court of law issues a legitimate subpoena; or when you are in treatment or being evaluated by order of a court of law.

I also understand and authorize Joan Forest LICSW to transmit electronic billing information to appropriate billing/funding agencies. Joan Forest LICSW conducts their own chart audits to stay in compliance with state and federal regulations regarding Independent Social Work practice. I also understand that charts and other notes are not taken off the premises of Joan Forest LICSW and are only reviewed with permission and guidance of Joan Forest LICSW and that requests beyond the scope of the above described would require a Consent for Release of Information form signed by me. _____Initial

I also understand that Joan Forest LICSW will charge $65 an hour minimum for all requests of summaries of treatment, court letters, or case management evaluations with medical, social services or legal professionals. These cannot be billed to my insurance and are therefore my sole financial responsibility. _____ Intial

I acknowledge I have received a copy of the following: 1) This treatment authorization; 2) Consumer Notice of Privacy Act; with Grievance Procedure; 3) Clinician Disclosure Statement regarding my counselor's education, experience, training, and Washington State Licensure.

I, _____, have read the above and I hereby authorize Joan Forest LICSW to evaluate, treat, and or provide consultation to the below named person.

Signature_____ Date_____