Toshia Shaw

Licensed Clinical Social Worker Intern

Office (725) 867-9374

**CONSENT TO TREATMENT**

* As part of this informed consent, it is important that I communicate to you my license status. I am a Licensed Clinical Social Worker Intern (CSW-I). A CSW-I is a state licensed independent psychotherapist (clinical social worker) who has completed a Master’s degree program, and currently under supervision from a Licensed Clinical Social Worker. My Nevada state license number is

IC-1828.

* As a client, your rights are guaranteed by the rules of ethical professional practice and the law. You have the right to:
	+ Mental health care and treatment
	+ To be advised about treatment choices and possible treatment concerns
	+ To refuse treatment
	+ To privacy
* Contents of all therapy sessions are considered confidential. Information about treatment is confidential and not released to anyone outside of the agency without your written consent. There are a few limitations to privacy and confidentiality. The ethical standards of therapists, and in some instances, state laws, require mandated reporting to responsible authorities when clients indicate any of the following:
	+ Threat to harm yourself
	+ Threat to harm someone else
	+ Abuse or neglect of a child, or if abuse or neglect is suspected by the therapist
	+ Abuse or neglect of an elderly person, or if abuse or neglect is suspected by the therapist

 Should I suspect any of the above issues, as a state mandated reporter, I must report such suspicions to the appropriate authorities; this can be done without your consent.

* Other limitations to your privacy include:
	+ Courts request to obtain your clinical record with a Court Order or judge signed subpoena
	+ Ex-spouses have the right to review their child’s record unless those rights have been terminated by the Court
* As a means to protect the confidentiality, in the event that I see my client(s) in public, I will not engage in conversation or acknowledge our association *unless* you, the client(s), approach me first. Further, if you, the client(s), do approach me or acknowledge our association, you accept the possibility that my and your nearby friends and/or family will become aware of your, the client(s), status as a client.

**OFFICE PRACTICES AND POLICIES**

* Therapy is a building block process. Each session builds on or complements previous sessions. Successful treatment depends on your regular attendance at each scheduled session. If you go 60 days without a therapy session, you will be discharged as an active client.
* You have a responsibility to pay for any services you receive before you terminate services. Fees accrued due to cancellations and/or no shows must be received on or before the next scheduled appointment. Further appointments will not be scheduled until a zero balance is obtained.
* ­Cancellation policy: If you are sick, have an emergency, or are unable to attend your scheduled session, please notify me or the office as soon as possible so I may adjust my schedule and reschedule you for another time. **Clients who no show or cancel less than 24 hours prior to their scheduled appointment will be charged the no show or late cancellation fee of $85 which will need to paid prior to rescheduling. \*\*\_\_\_\_\_\_\_\_\_\_ Initial Please\*\***
* **Clients who late cancel or no show 2 scheduled appointments in a 6-month period will be subject to termination from therapy. If you and I have established recurring appointments please note that one (1) late cancellation will also cause revocation of your standing appointment requiring that you make future appointments on a week to week basis depending on the availability of current appointment times. \*\*\_\_\_\_\_\_\_\_\_\_ Initial Please\*\***
* I do not participate in any court-related services for clients, including depositions, hearings, consultations with lawyers, or attendance at courtroom proceedings. I ask that you respect the integrity of the therapeutic process and refrain from asking for my participation.
* Record keeping: I am required by the law and standards of my profession to maintain appropriate treatment records. These may include diagnosis, therapy goals, your progress in treatment, documentation of mandated disclosures, and other information. You have the right to review and/or receive a copy of your records unless in my professional opinion, I find that doing so would likely cause you substantial harm, endanger your life or physical safety, or pose a significant risk of harm to another individual. If this is the case I will prepare an appropriate summary of these records. Given the use of professional language, my records may be difficult to interpret or understand. If you wish to review your records, I recommend that we review them together, so their content can be discussed.

**TELEPHONE AND EMERGENCY PROCEDURES**

* If you need to get a hold of me you may email me at toshia@flowinglotuscenter.com or call the front desk or leave a message for me with them and I typically will return phone calls within 24 hours. Messages are returned less frequently during the holidays and weekends. I generally do not return calls on the weekends or weekdays after 6PM. If you feel you are having a crisis, please contact the National Suicide Hotline at 800-273-TALK (8255) or if it is an emergency situation, call 911. If I am

unavailable for an extended period of time, I will provide the name and number of another qualified clinician whom you may contact if necessary. **\*\*\_\_\_\_\_\_\_\_\_\_ Initial Please\*\***

**Consent to treatment**: By your signature below, you are indicating the following:

* That you voluntarily agree to receive mental health assessment and mental health care, treatment, or services, and that you authorize me to provide such assessment and care, treatment, or services as I consider necessary and advisable.
* That you understand and agree that you will participate in the planning of your care, treatment or services, and that you may at any time stop such care, treatment, or services that you receive through me.
* That you have read and understood this statement and have had ample opportunity to ask questions about, and seek clarification of, anything unclear to you.
* That I provided you with a copy of this statement if asked for one.
* You consent for me to communicate with you by mail, e-mail, and/or phone and you will immediately advise me in the event of any changes to your methods of communication.

I give permission to Toshia Shaw, CSW-I to evaluate my case and provide treatment. I have read the office practices and policies and have had any questions answered about these policies. I understand and agree to the policies described above. I further understand that any psychotherapy has risks and benefits, but these cannot be fully described here in anticipation of a potential for treatment.

**I hereby authorize Flowing Lotus Center to release to my insurance company, or its representatives, any information including the diagnosis and the records of any treatment provided to me during the course of treatment.**

**I authorize and request that my insurance company pay directly to Changing Minds Psychiatry LLC, a third-party company, the amount due for services. I agree that I will be responsible for all co-pays, deductibles, and non-covered services. I further accept responsibility for verifying my insurance coverage. I understand and agree to a charge of $85 should I miss an appointment or fail to cancel prior to 24 hours of the appointment time. I understand that, in the event of non-payment, for any reason on my part, that Changing Minds Psychiatry may turn the balance over to a collection agency.**

Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_