CATHOLIC CHARITIES OF THE ARCHDIOCESE OF DUBUQUE
COUNSELING PROGRAM

C21 - Receipt of Client Information and Consent for Treatment

Name: _____ Date: _____

Receipt of Client Information

I have received the Catholic Charities' Information Handbook. This handbook contains the office hours, the mission and goals of the counseling program, my rights and responsibilities, rules of conduct, confidentiality and mandatory reporting requirements. Yes_____ No_____

I understand I can review the Grievance Procedures in the handbook and I can review my rights as a client outlined in the handbook. Yes_____ No_____

I have received a copy of Catholic Charities' Notice of Privacy Practices. Yes_____ No_____

I have been informed of the agency's policy regarding failure to cancel/reschedule appointments. Yes_____ No_____

I agree to be contacted by phone to be reminded of my appointments. Yes_____ No_____

I agree to be contacted by phone, mail or e-mail following completion of my services for the purpose of quality improvement. Yes_____ No_____

I agree that transmission of electronic mail to any Catholic Charities address represents my consent to two-way communication by Internet email. Yes_____ No_____

I have been informed that Catholic Charities does not have a 24-hour response and that counselors may not be in the office even during regular office hours, on occasion. Counselors may not be available to receive messages or return phone calls in the case of an emergency. I have been advised to call 911 or my local mental health 24-hour response service if I experience a mental health emergency.
Yes_____ No_____

Consent for Treatment

I consent to treatment at Catholic Charities for myself or for the person for whom I am the parent/legally authorized representative. I understand that Catholic Charities' services are provided by mental health professionals. (Services may also be provided by a "professional-in-training". All professionals in training are supervised by a licensed mental health professional). I understand that while mental health services may provide significant benefits, it also poses some risk. Counseling may cause thoughts, feelings, or memories to surface that may be uncomfortable or even painful. I acknowledge that no guarantees, expressed or implied, have been made to me concerning the effect of treatment and I will not hold my counselor or Catholic Charities responsible for any unforeseen or untold circumstance. My signature below indicates that I have reviewed and understand this form and consent to treatment.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date

Staff Initials_____