INFORMED CONSENT age 12-18

My name is Lisa Berg and I am the counselor you will be seeing today. My office address is 532 Lake Street and my phone number is 224-357-6793. Today's appointment will take about 60-90 minutes. I know that starting counseling is a big decision and you may have many questions. I will do my best to answer any questions or concerns. This form explains information about me, my policies, State and Federal Laws and your rights about counseling. My formal education includes a Bachelor of Social Work Degree and I have a Masters Degree in Social Work from the University of Illinois in Chicago. I am licensed by the State of Illinois as a Licensed Clinical Social Worker and have been helping people for over 18 years. In counseling I talk with people about how they can improve their coping skills, communicate better with their friends and family and feel better about themselves. This is called Solution Focused therapy. Other counseling approaches can be used depending on the person or condition. Counseling practices, philosophy and thoughts about how to help you and any risks of therapy will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: What we talk about and my notes are not shared with anyone without your written permission except for: 1. Diagnosis and dates of service and treatment plan shared with your insurance company to process your claims and your parent if requested. 2. Information you tell me about physical, sexual or elder abuse; then, by Illinois State Law, I have to report this to the Department of Children and Family Services/ Department of Health and Human Services. 3. When you sign a release of information to have specific information shared 4. If you tell me you are in danger of harming yourself or others. 5. Information shared with my consultant. 6. When required by law.

If you need to contact me between counseling sessions please call my number. I have a confidential voice mail. If you have an emergency situation and you receive my voice mail and/or it is after normal business hours you are instructed to call 911. I also have some resources for teenagers that can be accessed 24 hours a day 7 days a week. I also encourage you to talk with your parent if you are able to.

Signature_____Date:_____

COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, I would like your permission to communicate with your family Doctor and/or Psychiatrist. Your permission is good for one year. If you don't want me to communication with your Doctor, it is ok and no information will be shared. Please check the correct box below.

____ You may communicate with my Doctors(s)
____ You may not communicate with My Doctor(s)

PHYSICIAN NAME:_____
Clinic:_____
ADDRESS:_____
PHONE:_____

You have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization.

Signature_____***Date***_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I have read and/or received a copy of the Notice of Privacy Practices and Client Rights document.

May I contact you at home? (Circle one) **Yes No** May I contact you at work**? Yes No**
May I contact you by cell phone? **Yes No** Cell number_____
Where may I contact you and leave a message?_____

Signature_____**Date**_____

You may have a copy of this form if requested.