Therapy to Shine

Consent for Services

Name: ____

Date of Birth: ____

Consent for Services

Therapy to Shine is a private therapy practice, owned and operated by Debra Rachelle Ledbetter - Finley.

- As part of my request for services, I authorize Debra Rachelle MSW,/LCSW to provide behavioral health services.
- I may ask questions at any time.
- My participation is voluntary, and I may discontinue at any time.

Risks & Benefits

- There may be periods during services that may result in emotional discomfort, changes in relationships and temporary worsening of symptoms. The goal and intended benefit of services and supports is the resolution of the presenting problem.

Mandatory Reporting

- If, during services, I reveal past or threatened abuse of a person who is in a protected category, whether that person is myself or another individual, program staff must disclose and report such information as required by Oregon law. Individuals in the protected categories are children, elderly persons, developmentally disabled persons, and persons receiving mental health services covered by OHP or other public funding.
- If I threaten to harm myself or others, program staff are required to intervene, which may include a report to the appropriate agency and/or authority.
- In the event of threatened harm to any individual, program staff may warn the intended victim(s) by the most efficient means available.

Release of Information

- Therapy to Shine, Debra Rachelle will work with me to address physical and behavioral health needs.
- Debra Rachelle is bound by state and federal confidentiality rules.
- I understand that no information about me will be released to entities not involved in my care without my written authorization, except as described below.
- In cases of medical emergency, Debra Rachelle may access emergency medical treatment on my behalf. Information may be released to the attending emergency workers but will be limited to only information that is necessary to resolve the situation. Any information shared will be documented in my record.

Scheduling and Cancellations

- *I agree to keep scheduled appointments. I understand that I will be billed for missing an appointment if I do not give 24 hour notice.*
- *I will provide at least 24 hours advance notice if I need to cancel an appointment.*

My signature affirms that I have read and understand this form and have had the opportunity to ask questions.

Signature ____

Date : ____