RIVERSTONE
COUNSELING PROGRAM

Client Name:	Date of Birth:

Riverstone Counseling Program will make their treatment approach, program description, and admission and discharge criteria available to the public as part of the informed consent and orientation procedure.

Please check the box next to each sentence and sign at the bottom to acknowledge that:

- ☐ I have been given a copy of Spectrum's Consumer Notification of Orientation Policy.
- ☐ I have been given a copy of Spectrum's Consent and Agreement to the Use and Disclosure of Health Information for Treatment, Payment, or Health Operation.
- ☐ I have been given a copy of Spectrum's Counseling Services Policies and Information.
- ☐ I have been given a copy of my counselor's Professional Practice Disclosure Document.

By signing below I acknowledge that I have received, read, and understand the information outlined above, discussed and clarified any concerns I may have, and agree to these terms.

X _____ X _____
Client Signature and Date Parent/Guardian Signature and Date

I have received and understand the information provided to me regarding the use of telehealth services at Riverstone Counseling, and consent to the use of telehealth in the course of my assessment, diagnosis, and treatment.

X _____ X _____
Client Signature and Date Parent/Guardian Signature and Date

- ☐ I consent to digital communication regarding scheduling and appointments.
  - ☐ I prefer text communication regarding appointment reminders.
  - ☐ I prefer email communication regarding appointment reminders.
- ☐ I do not want text or email communication regarding appointments and scheduling and would prefer phone call reminders if they are available.

X _____ X _____
Client Signature and Date Parent/Guardian Signature and Date

I am the author and I approve this document
Witness Signature and Date: Amanda Talbert

X _____