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Treating Therapist Agreement for Clients in Peachtree DBT Skills Training

Client's Name: _____

Your client's class meets on _____ at _____

Treating Therapist

Please fill this form out and have client return to the class leaders.

This form must be filled out with your client fully aware with whom this information may be shared.

Treating Therapist Name: _____

Phone: _____ Email: _____

Cell Phone: _____ Fax: _____

Frequency of visits with client: _____

If your client is in crisis requiring immediate intervention what is the best way to reach you?

Who is your back-up therapist if you are unreachable? _____

You will be receiving a weekly informative email regarding skills taught that week. Please list your preferred email address: _____

Patient Information

Patient Diagnosis: _____

Is there a history of suicide, self-harm or injury to others? _____

Are there any issues of which we should be aware? _____

I am the primary individual therapist for the client referred to above. I understand that in order for my client to be eligible to participate in the DBT Skills Training Program with Peachtree Psychiatric Professionals, P.C., s/he must attend regular individual therapy sessions a minimum of every other week. As the primary therapist for this client I agree that I will:

1. Assume full clinical responsibility for my client.
2. Handle or provide back-up services to handle client clinical emergencies.
3. Be available by phone or provide a back-up provider phone number to call during skills training sessions of my client.

Therapist Signature: _____ **Date:** _____

After submitting this form, the skills training instructor will contact you to set up a brief phone consultation prior to the beginning of the module. The phone consultation is required to ensure the client is an appropriate fit for the skills class.