peachtree DBT

3520 PIEDMONT RD, NE
SUITE 350
ATLANTA, GA 30305

PHONE 404.351.2008
FAX 404.809.3321
WEB peachtreedbt.com

DBT Skills Class: Client Release of Information

Client Name: _____

Phone #: _____

Email: _____

Primary Therapist: _____

Phone #: _____

Email: _____

Class Day and Time: _____

I authorize full communication and the release of any pertinent medical information between my therapist and Peachtree DBT / Peachtree Psychiatric Professionals. I understand I will not be eligible to participate in the Peachtree DBT Skills Training Program unless I regularly attend individual therapy sessions on an on-going basis. **There will be a case management fee for all clients with an external primary therapist.**

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

After submitting this form to our office, the skills training instructor will contact your primary therapist to establish an open line of communication in order to discuss the client's diagnosis and any important clinical information.

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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

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.