# "THE TALK-IN CLINIC"
# CLIENT INFORMATION SHEET

**Welcome To Our Talk-In Clinic:**
This clinic provides quick access to single-session counseling services for families with children from birth up to 18 years of age. It also is the main "gateway" into other services at Children's Mental Health. Please see our brochure for more details.

Please complete the questionnaire(s) you were given by the Receptionist while waiting for the next available counselor. If the service area is busy, the Receptionist can give you an estimate of the waiting time. The counseling session will be about one hour long. The focus of the session is based on what you want from the meeting. Although many people find one session is enough, you may return to the Talk-In Clinic at any time even while you are on a wait list for services here.

**Parent Involvement:**
We believe that to help a child we must work in partnership with parents. This is true for youth, as well. However, youth 12 years of age or over have the legal right to private, confidential counseling although we usually encourage involvement of parents.

**Client Files:**
Each child/youth and family we see has his/her own file. The file may contain any of the following: information you have given us; written consents; correspondence received and sent for you; Talk-In questionnaires and Summary Report; Consent to Treatment; and the Confidentiality Statement. If you go on for further service, all information gathered at intake, assessment and/or treatment would then also become part of the file. You have the right to access your/your child's personal health information, which includes the client file.

**Rights and Responsibilities:**
We believe that as a client, you have certain rights and responsibilities. These include the right to confidentiality; to be treated with respect, honesty, and integrity; to receive competent and effective services; to withdraw from services at any time; to inform your counselor of any complaints about your/your child's services, to review your/your child's file with your/your child's counselor; to add information to the file that you may feel is important; and to request the correction of any factual errors in your/your child's file.

**Treatment Planning:**
All clients have the right to participate in assessment and treatment planning. At Children's Mental Health, we support you in voicing your treatment needs or desires and taking an active role in the creation of treatment goals. Treatment goals can be revised as needed.

**Evaluation:**
We also ask parents and youth who have used the service at our Talk-In Counseling Clinic to let us know what you thought of the service. The clinician you see will give you a "Talk-In Clinic Client Evaluation" form. Please try to complete this form at the end of your session and before you leave our office. In the event that you cannot do this, please mail it back to us with the questions completed as soon as you are able. It is very important that you give feedback that may assist us to modify, sustain or expand this service.

**Confidentiality:**
Services at Children's Mental Health are confidential, although there are exceptions when we must, by law, release information. The clinician who sees you will review these exceptions with you at the beginning of the session and ask you to sign a form indicating that you understand these, as well as another form agreeing to be involved in treatment (a single session at the Talk-In Clinic is treatment in this case). Your written consent is required to release information to persons outside this agency. **The exception to this agreement is our legal requirement to report suspicions of child abuse, or a child in need of protection to Child Protection Services or if subpoenaed, to provide information through a Court Order. The final exception to this agreement (when we must release information without consent) is to inform someone in authority if a family member is in imminent danger of hurting him/herself or others.**

**Cost:**
Our services are funded by the Ministry of Child & Youth Service and the Ministry of Health. Dufferin Child and Family Services is a registered charity and we appreciate donations to help fund special activities such as camps and tutoring. Donations exceeding $10.00 to the Dufferin Children's Fund will receive a tax receipt.

**Diversity:**
Dufferin Child and Family Services recognizes, welcomes and accepts the diversity of our clients and their families with respect to race, national or ethnic ancestry, place of origin, colour, religion, citizenship, creed, gender, sexual orientation, age, marital status, family status, mental or physical disability, or language. If you require services in a language other than English, we will make every effort to accommodate you.

**Problems/Complaint Process:**
Do you have a complaint? If you do, we want to hear about it. Dufferin Child and Family Services has a process for you to raise concerns about any aspect of the services we provide. If you would like more information about our complaint process please ask your Clinician or pick up our pamphlet *"When We Disagree: A Guide to DCAFS Complaint Process"* from our office.

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## COLLATERAL QUESTIONNAIRE (to be filled out by Professional Referent only)

*Please fill in all fields*

Name of Referent:_____

Your professional relationship to the child/youth:_____

Your **Agency/Service Affiliation**:_____

Your Agency/Service Affiliation Address:_____

Your Agency Phone: B#_____ C#:_____

**Child/Youth's Name:**

1)_____DOB____/____/_____ Age:_____School:_____GR____
YR MO DY
YR MO DY

Address:_____ Phone: Home_____
Phone: Work_____
_____ Phone: Cell_____
town postal code

Family Members:_____ DOB:_____
*(first and last name* _____ DOB:_____
*& relationship to client)* _____ DOB: _____
_____ DOB: _____

Child's Legal Guardian:_____ Lives with:_____

1. Has this family/child/youth received services from our agency (ie. Children's Mental Health Services) in the past? □ YES - Date_____ □ NO

2. List any other services involved:_____
_____

3. What concerns do you have about this family/child/youth?_____
_____

4. How would you rate your concerns for this family/child/youth?

| Worst 1 2 3 4 5 6 7 8 9 10 Best |
|---|

5. What is the one problem that seems important to work on now?

6. What would be important for us to know about the background of this problem?:

7. What is this family's/child's/youth's strengths?

8. What would you like to see accomplished in this meeting today?

9. In what ways do you currently provide support to this family/child/youth?

10. In what ways could you offer further or different support?

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Dufferin Child & Family Services
children's mental health • child protection • developmental support

# Consent to Disclose/Exchange Information

This consent is for the purpose of sharing information, to assist with planning & providing quality service

Name(s): _____
(client/parent/guardian) (relationship to client)

The information to be shared is about: ❑ myself ❑ my child(ren)

(name of child) (D.O.B.) (name of child) (D.O.B.)

(name of child) (D.O.B.) (name of child) (D.O.B.)

I/we authorize: ❑ To release information to ❑ To exchange information with

Name: Name:

Type of Disclosure: ❑ Verbal Information ❑ Copies of Records/Assessment ❑ Written Information

Specific Information to be released:

Purpose of release/exchange of information:

❑ I understand that the information to be shared is confidential and that it will not be shared with any other person/service unless Dufferin Child & Family Services is required by a court to share it or there is a risk of harm to self or others.

❑ I understand that consent to share information is voluntary and that I can withdraw my consent upon verbal or written notice to Dufferin Child &Family Services.

Unless otherwise revoked, this consent expires on: _____
(date/or file closing)

Signature: _____ Date: _____ Witness: _____
(client/parent/guardian)

Signature: _____ Date: _____ Witness: _____
(client/parent/guardian)

Signature: _____ Date: _____ Witness: _____
(client/parent/guardian)

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