Shannon Sorini, LCSW
1909 South 10th Ave. Caldwell, Idaho 83605 - 208-409-7286

PROVIDER INFORMATION

Shannon Sorini, LCSW - I received my Bachelor's degree in Social Work in May of 1997 at Boise State University and began my social work career. In December of 2005 I received my Master's degree in Social Work from Northwest Nazarene University and my Clinical Endorsement in December of 2010. I have enjoyed many areas of social work and continue to be passionate about assisting children and families who have experienced trauma. I use many theories of treatment in session to include but not limited to Cognitive Behavioral Therapy, Trauma Focused Therapy, Solution Focused, Brief Focused, Adlerian Therapy, Client Centered and EMDR.

INFORMED CONSENT

I consent to assessment, treatment and\or diagnostic procedures for myself or for my family member. I understand that the purpose of these procedures will be explained to me upon my request and subject to agreement. I authorize the release and exchange of information between my therapist and the referral source and other co-treating providers for the purpose of treatment, payment and Health Care Operations. I also authorize the release of information to my record in the case of therapist death or incapacitation to the designated person(s) for referral purposes. I also authorize the release of information to my health plan for claims or other health plan purposes.

____ ____________
Client/Legal Representative Date

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I/We _____________________________________consent that _________________________________
(Parent or Guardian) (Child's Name)
may be treated as a client by Shannon Sorini, LCSW. At times it maybe necessary to schedule appointments during school hours. Your cooperation is needed to provide the timeliest treatment for you and your children. In addition, I expect the non-custodial parent be informed of treatment and this parent is asked to be involved with treatment. Exceptions to this policy are as follows: the parent's whereabouts are unknown, the parent is deceased, the parent is incarcerated, a custody agreement does not require\allow the non-custodial parent's involvement (copy of the order must be provided), safety reasons and protections orders that involve the minor involvement (copy of the order must be provided).

____ ____________
Client/Legal Representative Date

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical or sexual abuse; then, by Idaho State Law, I am obligated to report this to the Department of Family and Children Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary and I am unavailable, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. **Initial**________

POTENTIAL RISKS: While we believe there are many benefits to therapy, there are also potential risks. These include but not limited to: unpleasant emotions during the process of therapy and experiencing change (not always exactly as desired) in relationships as a result of personal growth facilitated by therapy. **Initial**________

Please complete other side

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FINANCIAL/INSURANCE ISSUES: As a courtesy I will bill your insurance company, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay or the entire hourly fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Shannon Sorini, LCSW. Please note any out of office contact will be billed at the hourly rate and are not reimbursable by your insurance company.
I have reviewed a copy of the fee schedule Initial ______________

CANCELATION POLICY: If you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you may be billed at the hourly rate. Please be aware the insurance companies will not cover cancellation charges. I sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. **Initial ______________**

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS\HIPPA: I/We have read and understand I/We can received a copy of the, Notice of Privacy Practices and Client Rights document if requested.
I have reviewed a copy of the privacy form Initial ______________

ELECTRONIC COMMUNICATION: At times contact with Shannon Sorini, LCSW may be electronically, to include but not limited to e-mail, voice mail, social media and text. Please understand that any electronic communication shall be within the scope of scheduling and changing appointments. Electronic communication is to not be used for communication normally addressed in treatment sessions. I do not routinely check my electronic communications after business hours and may not return messages until the next business day. Telephone contact is acceptable for an emergency; please do not e-mail or text emergency situations as these may not be received by Shannon Sorini, LCSW. If an emergency situation for which the client or their guardian feels immediate attention is necessary and I am unavailable, the client or guardian understands that they are to contact the emergency services in the community (911) for those services.
Initial ______________

BUSINESS HOURS: Monday thru Thursday 9:00am – 5:00pm, unless otherwise communicated on my voice mail system, (i.e. vacations). **Initial ______________**

COURT: I do not recommend using therapy as a tool in any civil court case. I do not testify in civil court cases regarding any aspect of therapy as disclosing private information can be detriment to the client. If subpoenaed all travel, preparation, consultation and court time is at the subpoenaing parties expense at the rate indicated on the Fee Schedule form and can not be billed to insurance. Any canceled appearances are subject to billing for time scheduled.
Initial __________

Client Signature: ____Date_________________
(Client if over the age of 14 years)

Parent or Guardian Signature:____Date________________

Parent or Guardian Signature:____Date________________