



2265 Teton Plaza * Idaho Falls, Idaho 83404 * (208) 403-0135 Fax: (208) 209-8454

Navigating Your Home Program

CLIENT INFORMATION

Date _____

Name _____ S.S. # _____
Last First Initial

What name do you prefer being called (i.e. Kathleen, Kathy) _____

Address _____ Phone _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate ____/____/____ Single Married Widowed Divorced Separated

Employer _____ Occupation _____ Work Phone _____

Highest level of Education _____ College Degree (if applicable) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

RESPONSIBLE PARTY

Name _____ S.S. # _____

Address _____ Phone _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate ____/____/____ Single Married Widowed Divorced Separated

Employer _____ Occupation _____

Work Address _____ Work Phone _____

Family Members and ages:



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Navigating Your Home Consent for Treatment

Client Name: _____

Services

You have requested Navigating Your Home (NYH) services from Kristopher L. Walton & Associates, LLC (KLWA). Those services are delivered to clients on an appointment only basis. Frequency of services, objectives, and goals will be determined for each individual and/or family and will be based on need, progress, desire for services, and continued compliance with prearranged financial agreement.

NYH is designed to improve both individual and familial concerns and negative situations. The purposes and benefits of services described include a possible improvement of these issues. However, while services provided by KLWA adhere to the current standard of care in the Idaho Falls area and on the national level, there is no guarantee that those services will completely alleviate the issues to be addressed. Moreover, there are risks associated with these services, including a worsening of symptoms. KLWA staff is not liable for any injury or damage incurred as a result of providing ethical services. You thus have alternatives to the services provided by KLWA, including, but not limited to, seeking other forms of counseling, coaching, and psychotherapy. You have the right to withdraw your consent of treatment, refuse services, and/or seek services elsewhere at any time. You also have the right to choose the agency who delivers these services.

These services are for informational and educational purposes only. It is not medical advice for any condition, either as diagnosis or treatment. The information should not be viewed as a substitute for professional advice or assistance of licensed professionals. Please consult a healthcare professional for all matters relating to personal medical, health care or societal functioning issues. If you are a danger to yourself or others, please call your therapist, doctor, health care provider, or go to the nearest emergency room.

Travel/Transportation

Navigating Your Home Coaches are **NOT** permitted to drive clients or their families in their personal vehicle. Travel arrangements will have to be made to meet the Coach at your home, work or a predetermined location in the community.

Confidentiality

KLWA voluntarily adheres to HIPPA privacy standards for maintaining records. Video and audio recording is commonly used for consultation, review, and/or training and can increase service effectiveness. These recordings would be utilized without identifying information and only heard or viewed by KLWA staff that are bound by the law and obligated to adhere to the NASW code of ethics to protect your confidentiality. KLWA will not release any information or records to other parties or providers without your written consent. KLWA is obligated by law to disclose information if it is determined that you are a danger to yourself or others, or by legal subpoena. In these rare instances, only the required information will be shared with requesting parties.

By signing this document, you acknowledge that you freely choose and give your consent for KLWA to deliver services.

Client

Date

Printed Name

Relationship to Client



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Authorization Release

Permission to Record and Use of Recorded Material

Video and audio recording are commonly used for consultation, training and research in therapy. In order to record your session written consent is needed. The recording of sessions will likely enhance the effectiveness of your services, but is not required. You may decline to have sessions recorded.

Confidentiality

For any of the uses agreed to below, the strictest confidentiality will be maintained, and there will be no sharing of the recorded material beyond the limits specified below. Except your voice and/or image on the recording, there will be no information that could identify you. The recording will never knowingly be shared with anyone who knows you. Professionals who may view or hear recorded material of your session (if permission is given here) are bound by law and by code of ethics to the same obligation to protect your confidentiality. Except as noted below, the existence of this recording will not be discussed with anyone at any time.

_____ **Session Review Only**

The recording may be reviewed privately by Kristopher L. Walton & Associates staff for the purpose of ideas, techniques and theory for research of up and coming books, workshops and presentations. Information will be erased prior to the subsequent session. It will not be kept beyond the subsequent session and no recording will be kept beyond the conclusion of treatment.

_____ **Consultation**

The recording may be shared with a consultant who has been engaged to provide expert consultation regarding the service process. This consultation is a vital source of professional development and accountability; it provides additional provider expertise as a resource to your treatment and increases its effectiveness.

_____ **Training**

A brief recording excerpt may be used by Kristopher L. Walton & Associates staff in training to demonstrate concepts and techniques of services. No information which could identify you, beyond the content of the tape, will be shared.

Other Conditions (specify):

Freedom to withdraw consent

I/we understand that we may withdraw previously granted consent at any time without giving a reason, and that this will not affect our services or relationship with our service provider (s) in any way. I/we give our permission to Kristopher L. Walton & Associates to Audio/Video (circle one) record my/our therapy sessions for the purposes indicated above.

Client/Parent _____ Date _____

Client _____ Date _____

Witness _____ Date _____

Program Commitment Contract

- ↓ ____ I agree to meet with my service provider at scheduled dates and times prepared to put in the time and energy requested to participate fully in this program.
- ↓ ____ I will make every reasonable effort to communicate problems or changes in scheduling with my service provider within 24 hours of when services are scheduled to be rendered.
- ↓ ____ I will work individually and/or cooperatively with my family as needed to implement changes to the best of my ability.
- ↓ ____ I understand that I am responsible for creating my own physical, emotional, and mental wellbeing.
- ↓ ____ I agree to communicate honestly with my service providers.
- ↓ ____ I agree to be open to feedback and assistance from my service providers.
- ↓ ____ I commit to working toward accomplishing the program goals I develop with my service provider.
- ↓ ____ I understand that regardless of the information or guidance I am offered by my service provider, my decisions, actions, choices, and results are based on my level of commitment and involvement.

Signature

Date

For more information, questions or concerns you please contact:

Kristopher Walton: 208-403-0135