Statement of Informed Consent
For the Purpose of Receiving Treatment
and/or Evaluation Services with
Joseph Pereira, LICSW, CAS/OUTLOOK ASSOCIATES OF NEW ENGLAND

Joseph Pereira, LICSW, CAS is an independently licensed social work clinician in the state of Massachusetts. The purpose of Joseph Pereira's work is to offer professional counseling services to assist people in the goal of resolving personal, family or work related problems. The services that are provided by Joseph Pereira are assessment and evaluation, short term or long term individual psychotherapy and short-term group psycho-educational therapy.

Fees are charged for services provided by Joseph Pereira. Clients may self-pay for contracted services or use third party reimbursement depending on Joseph Pereira's ability to accept payment from a third party vendor.

The information presented to Joseph Pereira, LICSW, CAS is confidential. For quality assurance of client care, Joseph Pereira does occasionally share information with other licensed clinicians as part of receiving clinical consultation. Joseph Pereira, will not release information to anyone without your written permission except as required under the following circumstances:

- When you express your planned intention to harm yourself or your emotional or mental state is observed to put you at risk of harming yourself.
- You express that you intend to do bodily harm to another person. In that event, I am obligated by law to take reasonable precautions to ensure others' safety.
- You are under 18 years of age and you share that you are currently or have been sexually and/or physically abused, or it is determined that you are at significant risk of harming yourself
- Clinicians are mandated by law to report to the appropriate state authority information documenting child and elder abuse: or neglect.
- In certain legal proceedings, when a Judge seeks to review a record by use of a court order.
- In the event that I am seeking treatment from Joseph Pereira, LICSW, CAS and wish to use my health insurance or other third party payor to pay for these services, I agree to allow Joseph Pereira to release to the insurance carrier or other payor the information required to process the claim. I also agree to allow Joseph Pereira to discuss pertinent clinical data with a case manager from the insurance carrier or other third party payor as it relates to reimbursement of services or request for additional services provided by Joseph Pereira.
- In a legal proceeding where you introduce your mental or emotional condition.
- Information necessary to collect amounts owed to Joseph Pereira by you or a third party vendor that you may be using to pay for services.

I also understand that I may revoke my consent at any time except to the extent that action has been taken in reliance on it, and that in any event any consent will expire sixty days after discharge from treatment with Joseph Pereira, LICSW, CAS unless noted otherwise below.

Signature of Client:_____

Signature of Parent/Guardian:_____

Signature of Clinician: _____

Date: _____

Date of Expiration (If Requested): _____ _