Peer Counseling Program

APPLICATION FOR SERVICES AND CONSENT TO RECEIVE
PEER COUNSELING SERVICES

I, ________________________________________ agree to receive counseling services weekly (one hour) from the Peninsula Family Service Senior Peer Counseling Program. I understand that these services will/may be provided to me in my home.

I understand that the senior peer counselor will take my right to privacy seriously and will strive to keep peer counseling records confidential to the extent permitted by law. However, I understand that confidentiality guidelines and regulations governing therapist-patient privilege do not apply to senior peer counseling because the peer counselor is not a therapist. I understand that the senior peer counselor is supervised by a professional clinician in a monthly group supervision. I also understand that my senior peer counselor cannot accept gifts from me, or drive me in their car.

I realize that certain information may be released without my authorization under certain circumstances. For example:

- In the event of a valid medical emergency.
- If there is evidence to suggest that child, dependent adult or elder abuse has occurred.
- When a hazard to the public (such as homicide) requires disclosure.
- When there is any indication that I would be likely to do harm to myself.
- To the courts as necessary to the administration of justice.

I understand that the senior peer counselor and I will periodically review my services. I also understand that I can express my opinion to the Manager of the Senior Peer Counseling Program at any time. I understand and agree to the statements above, and I am aware that I can revoke this agreement at anytime and/or discontinue service.

Participant Signature_________________________________________Date________

Peer Counselor Signature______________________________________Date________
“This form was reviewed with the participant. The participant has verbally confirmed understanding the information provided above regarding Peer Counseling, and all of the participant’s questions have been answered.

Date/Time of Verbal Consent: __________

Signature/verbal confirmation of Participant ________________
Date/Time ________________

Signature of Peer Counselor confirming that informed consent was obtained ____________
Date/Time__________________

I AGREE TO THE PROVISION OF PEER COUNSELING, TELEPHONICALLY VIA THE TELEPHONE, ZOOM, SKYPE, FACE TIME, etc. FOR THE TIME PERIOD OF ONE YEAR, BEGINNING TODAY, (DATE) ________________.

Signature/ VERBAL AGREEMENT OF PARTICIPANT ______________________________
DATE/TIME ______________________

Signature of Peer Counselor confirming consent for telephonic peer counseling.

Obtained __________________ Date/Time

SIGNATURE OF SENIOR PEER COUNSELOR ________________________________

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