DBT - Enhanced Skills Training (EST)
Provider Agreement

Portland DBT INSTITUTE

Client Name:

Provider Name: Date:

I am the primary individual □ psychotherapist / □ case manager / □ pharmacotherapist for the client referred to Portland DBT Institute. I understand my client will not be eligible to participate in the DBT-EST Skills Training Program unless they attend regular individual treatment session on an ongoing basis. As the primary provider for this client, I agree that I will:

1. Assume full clinical responsibility for this client
2. Handle or provide backup services to manage client clinical emergencies
3. Be available by phone or provide a backup provider phone number to call during skills training sessions for my client
4. Provide and keep updated the Crisis Plan and Information from Primary Therapist Form
5. Help my client apply DBT skills to their clinical problems.

Provider Signature: