The Children's Place
2 East 59th Street • Kansas City, Missouri • 64113
Phone: (816) 363-1898   Fax: (816) 822-7711   www.childrensplacekc.org

Consent for Services Day Treatment

Date ______________________________

The Staff of The Children's Place appreciates your decision to participate in therapeutic services for:

____
(child's name)

The following lists ways we can ensure a positive experience and inform caregivers and guardians of the manner in which we provide treatment services.

_______ I have been given a copy of the Rights and Responsibilities Document.

_______ I have been given a copy of the Privacy Policy. I have been notified that I have the opportunity to request restrictions on the use and disclosure of my protected health information as well as to request confidential treatment of communications.

_______I have been given a copy of the Caregiver Handbook.

Please initial if you are in agreement:

Treatment

_______ I give consent for the child/family to receive **mental health** services from a qualified mental health clinician (all therapists have a master's degree in a mental health related field; all are licensed or provisionally licensed by the state of Missouri). Services may include individual therapy, family therapy, group therapy, psycho-education, and case management.

_______ I understand that I will be informed if the mental health therapist I am working with is provisionally licensed or clinically licensed.

_______ I understand that The Children's Place mental health therapists utilize best-practice treatment. Therapists are formally trained in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent Child Interaction Therapy (PCIT), Eye Movement Desensitization and Reprocessing (EMDR), and Play Therapy. The therapist will assess my child's mental health needs and with caregiver input will develop a treatment plan using one or more of these treatment modalities.

_______ I give consent for the child to participate in **speech and language** services from a qualified speech and language pathologist and supervised graduate students. Services may include individual evaluations, individual therapy, and classroom group instruction.

________ I give consent for the child to participate in **occupational therapy** services provided by a qualified occupational therapist. Services may include individual evaluations, individual therapy, or classroom group instruction.

________ I give consent for the child to be observed in the classroom setting by a licensed **child psychiatrist** to determine if further evaluations would be appropriate.

________ I understand that therapy is not an exact science and every effort will be made to create positive change in my child. I also understand that during treatment the child may experience a worsening of symptoms and that the therapist will monitor and work closely with my family to help move through these difficult times and will recommend additional resources or services if necessary.

________ I understand that The Children's Place believes that caregivers should be involved in the treatment planning process. If there are disagreements about what is in the best interest of the child, the therapist will listen carefully and attempt to communicate clearly so all perspectives may be addressed. The therapist may discuss the case in supervision or staffing to obtain additional guidance. Families may follow policy regarding filing grievances if the situation cannot be resolved through face to face communication.

________ I understand that it is my responsibility to participate in the development of treatment plans and to attend the Staffing Meetings which are held when the child has attended The Children's Place for 30 days and every six months thereafter.

________ I understand that if I *have legal guardianship of my child*, I can withdraw my child from treatment at anytime, but understand that this decision should be discussed with the therapist/case manager to create a positive termination.

Mandated Reporting and Release of Information

________ I understand that employees of The Children's Place are mandated by law to report information concerning possible neglect and abuse of children and/or older adults in Missouri and Kansas. We also retain the right to consult with professional colleagues concerning this type of situation if we deem it to be necessary.

________ I understand that strict confidence is maintained and enforced. Information I provide to The Children's Place staff will not be released without my written authorization (or that of my personal representative) unless:

(1) The Children's Place is compelled to release such information by a court order;
(2) An individual's physical safety is threatened, or;
(3) The child's legal/parental guardian requests pertinent information.

________ If the child/family is involved with The Children's Division or the Family Court System, The Children's Place may be required to provide information about child's participation and progress in treatment

________ I understand that under Missouri and Kansas law, the court has the power to order us to disclose information given to us by clients when:

(1) Such information pertains to criminal acts or violations of any law or any proceeding in a court of law.
(2) When the information concerns matters of adoption, child neglect, or child abuse, or other matters pertaining to the welfare of children.

Supervision and Treatment Team

________ I understand that in this treatment agency, client information may be shared both verbally and through written documentation during clinical supervision with a licensed supervisor or the case record may be reviewed by other members of the treatment staff for educational and quality improvement purposes only.

________ I understand that Day Treatment Services are provided by an interdisciplinary team: who meet regularly to discuss child's treatment progress. The following individuals may also be included in the interdisciplinary meeting; interns, classroom volunteers, members of the Board of Directors and representatives from the Children's Division. All sign a confidentiality contract.

________ I understand that The Children's Place is an internship site for several local universities to provide training for social workers, counselors, psychiatrists, speech language pathologists and educators. Students sign and abide by a confidentiality contract. Students may review records, participate in agency meetings and treatment planning as well as work directly with my child. Any work they do is closely supervised by a qualified staff member.

Media Release

________ I provide consent for my child to be photographed at The Children's Place, for use only **within the facility.** (Classroom pictures and portfolio, bulletin board displays).

________ I authorize the release of my child's art work to The Children's Place. I understand that the art work may be displayed at the agency, but my child's name or identifying information will not be shown with the art. This release permits use of my child's art in classroom displays, bulletin boards and marketing/public awareness materials.

________ I provide consent for my child to be photographed and videotaped for **publicity** purposes. I understand that no identifying information about my child or my family will be used. I understand that the picture may be used in marketing materials/training information.

________ I understand that some treatment sessions may be recorded (including PCIT). I understand that **I will be notified** ahead of time, if there are recordings being made. Recordings may be shared with families to enhance the therapeutic process or with other mental health professionals for educational/clinical supervision purposes only.

Attendance

The Staff of The Children's Place have learned that that regular attendance is critical for helping a child heal and grow. We realize that illness and other circumstances come up from time to time. If there are particular issues that affect your child's attendance, please share these with the child's therapist or teacher, to see if we can assist in solving them.

_______ I understand that it is expected for my child to attend The Children's Place five days a week. If he/she is unable to attend, I will call the main phone number and leave a message or speak with the receptionist before 8:30am on the day of the absence.

_______ I understand that if my child is ill,(fever, diarrhea or vomiting within last 24 hours) he/she should not be sent to The Children's Place. It is my responsibility to call the teacher, before 9 am and let him/her know my child will not be present.

_______ If my child becomes ill during the day, I will be notified by the staff and it is my responsibility to transport the child home or to a physician/hospital.

_______ I will make every attempt to schedule appointments and visits outside of classroom hours.

_______ I understand that inconsistent attendance may lead to the child being discharged from the program.

_______ I understand that the Children's Division may be notified if a child is absent frequently or for an unexplained amount of time.

Program Evaluation

________ I understand that, to document the progress of children and families who receive services at the Children's Place, I will be asked to complete surveys about my child's development and behaviors and about my experiences parenting throughout my child's treatment. I understand that I will be contacted to complete surveys every 3 months. Surveys will take approximately 60 to 90 minutes and can be completed at The Children's Place, over the phone, via home visits by a The Children's Place staff member, or via a location in the community.

________ I understand that my child will also be directly assessed to track his/her developmental progress (e.g., language, motor skills, etc). This will occur during the day while my child is at The Children's Place.

________ I understand that Day Treatment teachers and therapists will also be asked questions about my child's behavior and emotional states.

________ I understand that I have the right to request these results at any time and that results will be shared during Caregiver Staffing Meetings, 30 days and every 6 months while receiving treatment.

________ I understand that results from this information will help TCP staff to:

1) Plan and track appropriate treatment goals with me for my child
2) Understand how and why children improve
3) Identify areas where The Children's Place can improve programs for children and families.
4.) Evaluate the effectiveness of treatment and share with other programs and funders.

Additional Information

________ I have been informed of the agency's Behavior Management policy and understand that my child may be restrained if s/he is of danger to himself or others. I understand that all positive guidance techniques will be used.

_______ I understand that a copy of the agency licenses and accreditations are posted in lobby and that a copy of the licensing rules for a Missouri Child Care center is available for review.

______ I give permission for my child to sleep on a cot during naptime.

_______ I give permission for The Children's Place to provide personal care and /or change of clothes in the case of toileting accidents, spills and other hygiene needs.

_______ I agree to provide all the health forms required for my child to remain enrolled. I understand that if I do not provide a current Medical Exam form and immunization records, my child will not be able to attend the program.

INFORMED CONSENT

I affirm that I have been informed of the therapeutic services available at The Children's Place. I agree that The Children's Place and its staff members have my full consent to perform those services which have been reviewed and initialed above.

I affirm that I am the minor's legal guardian or authorized representative.

Signature ____Print Name___________________

Relationship to the Child ____Date _____________________________

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FOR FOSTER AND KINSHIP CAREGIVERS ONLY

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_______ I have been given a copy of the Privacy Policy.
I have been notified that I have the opportunity to request restrictions on the use and disclosure of my protected health information as well as to request confidential treatment of communications.

_______ I have been given a copy of the Caregiver Handbook.

_______ I have received a copy of this consent form.

Signature ___________________________________ Print Name ____________________________________

Relationship to the Child ____________________________ Date ______________________