



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 Outpatient Treatment

Date:

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

(client name)

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

Please initial if you are in agreement:

_____ I have been given a copy of the Client's Rights and Responsibility Statement.

_____ 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.

Treatment:

_____ I give consent for the child/family to receive mental health services from a qualified mental health therapist (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, psycho-education and/ or case management.

_____ I understand that I will be informed if the 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 the child's mental health needs and with caregiver input, will develop a treatment plan using one or more of these treatment modalities.

_____ I understand that The Children's Place believes that caregivers are critical to the treatment planning process for the child. Caregivers are most knowledgeable about a child's behavior and temperament. 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 The Children's Place policy regarding filing grievances if the situation cannot be resolved through face to face communication.

_____ I understand that therapy is not an exact science and every effort will be made to create positive change in the child. I also understand that during treatment a child may experience a worsening of symptoms. 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 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 and The Children's Place requests that two closing sessions be allowed to facilitate a healthy ending to the treatment relationship.

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 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.

_____ I understand that under Missouri and Kansas law, the court has the power to order The Children's Place 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.

_____ 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 regarding your family's involvement and progress in the agency's services.

Supervision:

_____ I understand that in this treatment agency, client information may be shared among staff, both verbally and through written documentation. This may be done through clinical supervision with a licensed supervisor or the case record may be reviewed for educational and quality improvement purposes only.

Additional Information:

_____ I understand that if my child is ill (fever, diarrhea or vomiting within last 24 hours), he/she should have their appointment rescheduled. I understand it is my responsibility to notify TCP staff of this.

_____ 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.

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 were reviewed above.

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

Signature:_____ Date:_____

Relationship to the Child:_____