CONSENT TO RECEIVE SERVICES

I, [signature], consent to receive services and/or consent to services for [name] (my minor child). I give permission for review of my case by Child Saving Institute staff, supervisors, and clinical consultants. I have received and been informed of my rights and responsibilities as an agency client. No case information will be shared with any other agency, institution, or individual unless an “Authorization for Release of Information” form is signed by me. In the event that I or my minor child threaten harm to self or others, this confidentiality policy no longer applies.

Acknowledgement of Child Saving Institute’s Privacy Practices:

I have read and I understand Child Saving Institute’s Notice of Privacy Practices. I understand that I may request a copy of the Notice of Privacy Practices at any time.

_________________________   __________________________
Signature                  Date

_________________________   __________________________
Client Signature            Date

_________________________   __________________________
Client Signature            Date

_________________________   __________________________
Parent/Guardian Signature   Date
Client Information Form

The following are questions about personal history which will help your therapist understand your situation. Your therapist will review this information with you during your first meeting. If you have questions about anything asked on this form, please discuss this with your therapist.

**Client Information:**

Name of Client: ___________________________ Age: _______ Date of Birth: _______

Ethnicity: □ African American □ Caucasian □ Hispanic/Latino □ Asian □ Native American □ Bi-Racial □ Native Hawaiian/Pacific Islander □ Multi-Racial □ Other: ___________________________

Client Income: □ under 10,000 □ 10,000 – 19,999 □ 20,000 – 29,999 □ 30,000 – 39,000 □ 40,000 to $49,999 □ 50,000 to $59,999 □ 60,000 and up

Religion: □ Buddhist □ Catholic □ Christian □ Jewish □ Methodist □ Protestant □ No Affiliation □ Other: ________________

Today’s Date: ___________ Referred by: _______________________

Name of Person Completing Form: ___________________________________ Relationship to the Client: _______________________

**Social and Family History:**

Describe any critical events and the client’s reaction to them for example: divorce of parents, deaths in the family, separations from parents, move, any traumatic or scary experiences:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

People Who Live in the Household and Any Other Significant Relationships:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age/DOB</th>
<th>Relationship to Client</th>
<th>Lives in the Household?</th>
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<td>□ YES □ NO</td>
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</table>

**Current Concern:**

Please briefly state the current problem(s)/concern(s). What has led to you seek therapy services at this time?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Are there currently any other counselors, social service professionals, school social workers/psychologists, or court offices involved with your child or family? □ Yes □ No
If yes, who?
1: ____________________________________________
2: ____________________________________________
3: ____________________________________________

**Client's Educational History:**

Highest Grade Completed/Currently Enrolled in: ________________________

Check the Following School Concerns that Apply:
□ Refusal to go to school □ Attendance problems □ Retained in a grade □ Learning Disorder
□ Behavioral problems □ Referral for special help □ Academic problems

School Name: ______________________ Teacher’s Name: ______________________ Phone Number: ____________

May the therapist call and discuss your child with school personnel? □ Yes □ No

**Client's Employment History:**

Employment Status:
□ Unemployed □ Part-time □ Full-time □ Not Applicable (Client is a Child)

Name of Current Employer: ______________________ Main Source of Income for Family: ______________________

**Medical History:**

**Client's Mother's Pregnancy/Birth of Client:**
Mother’s Medical Problems During Pregnancy: ____________________________________________

Delivery: □ Premature □ Full-term □ Late

Birth Weight: ___lbs. ___ozs.

At what age did the client begin: walking _______ talking _______ toilet training _______

Were there any concerns with your child’s development? □ Yes □ No

Medical History of the Client (to include any medical concerns, surgeries, etc):

________________________________________________________________________________

________________________________________________________________________________

Allergies: __________________________________________________________________________

Current Medication (to include over the counter medications and supplements):

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Start date</th>
<th>Prescribed by:</th>
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</tbody>
</table>
Doctors Name: ____________________ Phone #: ____________________ Date of Last Physical: ____________

May the therapist be in contact with the Primary Care Physician? □ Yes □ No

Dentist: __________________________ Date of Last Dental Exam: ________________
Dental Concerns: ____________________________________________________________

Mental Health Treatment History:

Age Symptoms/Problems First Began: ______ Has the client been given a mental health diagnosis? □ Yes □ No
If yes, what was the diagnosis? ________________________________________________

Therapy History:
Therapist Name


Company


Dates

Hospitalizations:
Facility


Dates


Psychiatrist’s Name: ________________ Phone #: ____________________ Date of Last Appointment: ____________

May the therapist be in contact with the Psychiatrist? □ Yes □ No

Any history of chemical/substance use for the client? □ Yes □ No

Does the client have a history of any kind of abuse? □ Yes □ No

□ Physical Abuse □ Domestic Violence □ Community Violence □ Neglect
□ Emotional Abuse □ Sexual Abuse □ Other:

Other information you would like the therapist to be aware of:

__________________________________________
__________________________________________
__________________________________________
RECEIPT OF CLIENT RIGHTS AND RESPONSIBILITIES

I, ____________________________________________ received a copy of the following:

☐ Child Saving Institute’s Client Rights and Responsibilities
☐ Magellan Member Rights and Responsibilities (Medicaid funding only)
on __________________________. I have had an opportunity to ask questions and receive clarifications about this information as applicable.

_________________________________________  __________
Signature                                                  Date

Relationship to Client:

☐ Self
☐ Parent
☐ Legal Guardian

**********************************************************************************

I, ____________________________________________, was offered a copy of the following:

☐ Child Saving Institute’s Client Rights and Responsibilities
☐ Magellan Member Rights and Responsibilities (Medicaid funding only)
on __________________________ and declined to accept this information.

_________________________________________  __________
Signature                                                  Date

Relationship to Client:

☐ Self
☐ Parent
☐ Legal Guardian

**********************************************************************************

I, ____________________________________________, provided a copy of the following:

☐ Child Saving Institute’s Client Rights and Responsibilities
☐ Magellan Member Rights and Responsibilities (Medicaid funding only)
to __________________________________________, on __________________________ via ☐ hand delivery / ☐ mail / ☐ fax.

_________________________________________  __________
Signature                                                  Date
Primary Care Physician Communication Form

☐ I __________________________ (Client/Legal Guardian) do wish Child Saving Institute’s provider to be in contact with my/child’s Primary Care Physician and did sign an authorization for them to do so. (Please complete box below)

☐ I __________________________ (Client/Legal Guardian) do not wish Child Saving Institute’s provider to be in contact with my/child’s Primary Care Physician and did not sign an authorization for them to do so. (No further information needed)

Client/Legal Guardian Signature: __________________________

Client Name: __________________________ Client Date of Birth: ____________
Primary Care Physician’s Name: __________________________
Physician’s Address: ______________________________________
Physician’s Phone: __________________________ Physician’s Fax: ____________

Dear Colleague:
I saw the above-named client, who gave an authorization to release the following information, on ____________ for __________________________
(Date) (Reason/Diagnosis)

Brief Summary (if indicated):
________________________________________________________

Current Treatment (interventions by Child Saving Institute providers):
☐ Individual Psychotherapy ☐ Family Psychotherapy
Date client met with Psychiatrist (if applicable): __________________________
☐ Medication(s) Prescribed: ______________________________________

☐ Patient Refused Medication

Other Treatment Recommendations (interventions requested of receiving practitioner):
Please assess for medical conditions that could cause or contribute to Mental Health Diagnosis.
________________________________________________________

The patient ☐ has ☐ has not received a copy of this form. If you have any questions or would like additional information, please contact me.

Thank you,

Clinician Signature: __________________________ Date Sent/Faxed: ____________

Child Saving Institute ~ 4545 Dodge Street ~ Omaha, NE 68132 ~ (p) 402-553-6000
Child Saving Institute
AUTHORIZATION FOR RELEASE OF INFORMATION
(Primary Care Physician)

Section A: Must be completed for all authorizations
I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal privacy regulations.

_________________________________________  ________________________________________
Client Name                                               Social Security Number

_________________________________________  ________________________________________
Client Address                                             Date of Birth

I authorize my assigned CSI service provider, service provider’s supervisor, and/or designated administrative support staff to:

_________________________________________
Release information to:

Address: _______________________________________

_________________________________________
Release information from:

Address: _______________________________________

The information requested is needed for the following purpose:

   X Treatment   ___ Planning and Coordination   ___ Other: _____________________________
   (Specify)

And such disclosure shall be limited to the following specific information:

   X  Health Information: Diagnoses / Assessment / Service/Treatment Plan / Progress Notes / Discharge Summary
   ___ Psychological Evaluation
   ___ Social History
   ___ Educational Information: Transcripts / IEP/IFSP / Attendance / Behavioral Information / Other ____________________________
   ___ Substance Abuse/Chemical Dependency Evaluation/Treatment Information
   X  Other (Specify): Primary Care Physician Communication Form

Section B: Must be completed only if a health plan or health care provider has requested the authorization
The client or the client’s representative must read and initial the following statements:
   a. I understand that treatment will not be denied if I refuse to sign this authorization ______ (initial), unless specific circumstances exist where authorization is required as part of treatment.
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I receive a copy of this form after I sign it. ____ (initial)

Section C: Must be completed for all authorizations
The client or the client’s representative must read and initial the following statements:

   a. This authorization is effective from ___________________________ to ___________________________.
   *Expiration must be within 90 days for a one time request or within one year for ongoing service provision.
   b. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any effect on any actions they took before they received the revocation. ______ (initial)

*Warning: The confidentiality of this information is protected by Federal Law (42CFR). No further disclosure of this information is allowed without the above-named person’s written consent specifying release of this information in accordance with Federal regulations.

_________________________________________  ________________________________________
Signature of Client or Client Representative                              Date

_________________________________________
Signature of Witness                                              Date

Form must be completed before signing

_________________________________________
Printed Name of Client/Representative                                      Date

_________________________________________
Relationship to Client                                                   Date

**You May Refuse To Sign This Authorization**
CHILDSAVING INSTITUTE
OUTPATIENT THERAPY PAYMENT AGREEMENT

Instructions: Please check the type of payment you plan to use for therapy services. Fill in the information in one section only.

☐ MEDICAID COVERAGE - Complete this section if you plan to use Medicaid benefits to pay for therapy services. (Please provide copy of Medicaid Card.)

Name of Parent/Guardian: __________________ Name of Client: __________________
Client DOB: _________ Client Medicaid #: __________________
Name of Medicaid Plan: _____Nebraska Total Care _____United Healthcare Community Plan
____ WellCare Is Medicaid Active? Yes _____ No _____

Please Sign Page 2

☐ PRIVATE INSURANCE - Complete this section if you plan to use Private Insurance to pay for therapy services. (Please provide a copy of your insurance card.)

Name of Parent/Guardian: __________________ Name of Client: __________________
Name of Policy Holder: __________________ Policy Holder DOB: __________________
Policy Holder’s relationship to client: __________________
Name of Insurance Provider: __________________ Provider’s Phone Number: __________
Group Name or Policy Number: __________________

Please Sign Page 2

☐ SELF PAY/Sliding Scale Rate Request - Complete this section if you plan pay for services using cash, check, credit card, or automatic withdrawal and are requesting a sliding scale rate for services. Sliding scale rates are not guaranteed and must be approved by the Program Director. The cost of therapy services range from $110-$227 per session.

Name of Parent/Guardian: __________________ Name of Client: __________________

What is the amount you are able to pay for each therapy session? __________
What is your household annual income? __________
How many people live in your household? __________

Based on this information your sliding scale rates are: (To be completed by CSI Personnel)

$ ______ Individual Session
$ ______ Family Session
$ ______ Pre-Treatment Assessment

Please sign page 2. My signature on the next page attests that the information provided is accurate and up-to-date. I agree to notify Child Saving Institute of any changes to my financial situation and this could affect the amount owed in the future.
□ CONNECTIONS Program - Complete this section if your child is enrolled in Project Harmony’s Connection Program and you have requested assistance with paying for services.

Name of Parent/Guardian: __________________________ Name of Client: __________________________

Have you requested and been approved for assistance from the Connections program?  
Yes  No

As part of the agreement, will you be paying a portion of the fee?  Yes  No

If yes, what is the amount you will pay?  $__________

As part of the agreement, has Connections agreed to pay all or part of your insurance deductible?  
Yes  No

If known, what is the amount Connections has agreed to pay?  $__________

Please sign below.

________________________________________________________________________

I acknowledge I am responsible to pay for services. I agree to pay for services at the time of service unless other arrangements have been made. I also agree to immediately notify CSI of changes in my insurance or financial status. CSI may request additional information to include but not limited to proof of income.

I hereby authorize Child Saving Institute to release any and all clinical information necessary to determine benefits to an authorized representative of the my insurance provider or other payor.

________________________________________________________________________

Name of Client/Legal Guardian (PRINT) __________________________ Date __________

________________________________________________________________________

Signature of Client/Legal Guardian __________________________

________________________________________________________________________

Child Saving Institute Personnel __________________________ Date __________

________________________________________________________________________

Approval by Program Director  
(Required for Sliding Scale Requests Only) __________________________ Date __________

9/21/16

Page 2 of 2
Child Saving Institute

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal privacy regulations.

__________________________          ____________________________
Client Name                          Social Security Number

__________________________          ____________________________
Client Address                      Date of Birth

I authorize my assigned CSI service provider, service provider's supervisor, and/or designated administrative support staff to:

__________________________
Release information to:

__________________________
Address:

__________________________
Release information from:

__________________________
Address:

The information requested is needed for the following purpose:

_____ Treatment       _____ Planning and Coordination     _____ Other:

(Specify)

And such disclosure shall be limited to the following specific information:

_____ Health Information: Diagnoses / Assessment / Service/Treatment Plan / Progress Notes / Discharge Summary
_____ Psychological Evaluation
_____ Social History
_____ Educational Information: Transcripts / IEP/IFSP / Attendance / Behavioral Information / Other
_____ Substance Abuse/Chemical Dependency Evaluation/Treatment Information
_____ Other (Specify)

Section B: Must be completed only if a health plan or health care provider has requested the authorization

The client or the client's representative must read and initial the following statements:

a. I understand that treatment will not be denied if I refuse to sign this authorization ________ (initial), unless specific circumstances exist where authorization is required as part of treatment.

b. I understand that I may see and copy the information described on this form if I ask for it, and that I receive a copy of this form after I sign it. ________ (initial)

Section C: Must be completed for all authorizations

The client or the client's representative must read and initial the following statements:

a. This authorization is effective from ___________________________ to ___________________________.

*Expiration must be within 90 days for a one time request or within one year for ongoing service provision.

b. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any effect on any actions they took before they received the revocation. ________ (initial)

*Warning: The confidentiality of this information is protected by Federal Law (42CFRII). No further disclosure of this information is allowed without the above-named person's written consent specifying release of this information in accordance with Federal regulations.

__________________________          ____________________________
Signature of Client or Client Representative                          Date

__________________________          ____________________________
Signature of Witness                          Date

Form must be completed before signing

__________________________          ____________________________
Printed Name of Client/Representative                          Date

__________________________          ____________________________
Relationship to Client                          Date

**You May Refuse To Sign This Authorization**
Child Saving Institute
AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal privacy regulations.

Client Name

Social Security Number

Client Address

Date of Birth

I authorize my assigned CSI service provider, service provider’s supervisor, and/or designated administrative support staff to:

____ Release information to:

Address:

____ Release information from:

Address:

The information requested is needed for the following purpose:

____ Treatment  ____ Planning and Coordination  ____ Other: (Specify)

And such disclosure shall be limited to the following specific information:

____ Health Information: Diagnoses / Assessment / Service/Treatment Plan / Progress Notes / Discharge Summary
____ Psychological Evaluation
____ Social History
____ Educational Information: Transcripts / IEP/IFSP / Attendance / Behavioral Information / Other
____ Substance Abuse/Chemical Dependency Evaluation/Treatment Information
____ Other (Specify)

Section B: Must be completed only if a health plan or health care provider has requested the authorization

The client or the client’s representative must read and initial the following statements:

a. I understand that treatment will not be denied if I refuse to sign this authorization[initial], unless specific circumstances exist where authorization is required as part of treatment.

b. I understand that I may see and copy the information described on this form if I ask for it, and that I receive a copy of this form after I sign it. __________ (initial)

Section C: Must be completed for all authorizations

The client or the client’s representative must read and initial the following statements:

a. This authorization is effective from __________ to __________.

Date  Date

*Expiration must be within 90 days for a one time request or within one year for ongoing service provision.

b. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any effect on any actions they took before they received the revocation. __________ (initial)

*Warning: The confidentiality of this information is protected by Federal Law (42CFR). No further disclosure of this information is allowed without the above-named person’s written consent specifying release of this information in accordance with Federal regulations.

Signature of Client or Client Representative

Date

Signature of Witness

Date

Form must be completed before signing

Printed Name of Client/Representative

Date

Relationship to Client

Date

**You May Refuse To Sign This Authorization**
Child Saving Institute

AUTHORIZATION FOR RELEASE OF INFORMATION

(Emergency Contact)

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal privacy regulations.

Client Name

Client Address

Social Security Number

Date of Birth

I authorize my assigned CSI service provider, service provider’s supervisor, and/or designated administrative support staff to:

__X__ Release information to: (emergency contact name)

Address/Phone:

Address/Phone:

The information requested is needed for the following purpose:

Treatment  Planning and Coordination  __X__ Other: Emergency Contact

(Specify)

And such disclosure shall be limited to the following specific information:

__Health Information: Diagnoses / Assessment / Service/Treatment Plan / Progress Notes / Discharge Summary
__Psychological Evaluation
__Social History
__Educational Information: Transcripts / IEP/IFSP / Attendance / Behavioral Information / Other
__Substance Abuse/Chemical Dependency Evaluation/Treatment Information
__X__ Other (Specify): Emergency Contact

Section B: Must be completed only if a health plan or health care provider has requested the authorization

The client or the client’s representative must read and initial the following statements:

a. I understand that treatment will not be denied if I refuse to sign this authorization ________ (initial), unless specific circumstances exist where authorization is required as part of treatment.

b. I understand that I may see and copy the information described on this form if I ask for it, and that I receive a copy of this form after I sign it. ________ (initial)

Section C: Must be completed for all authorizations

The client or the client’s representative must read and initial the following statements:

a. This authorization is effective from ________ to ________. Date

*Expiration must be within 90 days for a one time request or within one year for ongoing service provision.

b. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any effect on any actions they took before they received the revocation. ________ (initial)

*Warning: The confidentiality of this information is protected by Federal Law (42CFR). No further disclosure of this information is allowed without the above-named person’s written consent specifying release of this information in accordance with Federal regulations.

Signature of Client or Client Representative

Date

Signature of Witness

Date

Form must be completed before signing

Printed Name of Client/Representative

Date

Relationship to Client

Date

**You May Refuse To Sign This Authorization**