

Dear Family:

The School Based Clinic in your child's school offers mental health counseling as one of its services. We employ therapists who are fully licensed by the State of Minnesota and therapists who are working towards State of Minnesota licensure. University students in Professional Mental Health graduate programs also provide services at the School Based Clinic.

Counseling and therapy is the process where mental health issues are assessed and treated. There are a variety of therapeutic techniques that can be utilized to deal with the problem(s) that bring people to therapy. These services require your participation and cooperation. Current and future circumstances may require services to be provided by Telemedicine; the practice of mental health care delivery, diagnosis, consultation, treatment and education using interactive audio, video or data communications.

This document contains important information about our professional service policies. Please read it carefully and note any questions you might have so you can discuss them with your child's therapist. Once you sign this consent form it will constitute an agreement between you and your child, the therapist and the School Based Clinics. Signing this form also gives the School Based Clinic permission to gain access to attendance and grades for your child to further assess how our services may be benefiting your child. In the course of therapy, you and/or your child may be asked by the therapist to participate in a diagnostic assessment session and to assist in developing treatment goals and plan. This consent form also gives the School Based Clinic permission to share service information with research databases for the purpose of allowing researchers or outside evaluators to evaluate the quality of services provided.

Counseling and therapy has both benefits and risks. Possible risks include the experience of uncomfortable feelings such as sadness, anxiety, anger, frustration, or the recall of unpleasant past events. For telemedicine risks, benefits and consequences include but are not limited to disruptions of transmission by technical failure, interruption and/or breaches of confidentiality by unauthorized persons and/or limited ability to respond to emergencies. Your child will be given contact information for afterhours care should they need service after clinic hours. Potential benefits include significant reduction in feelings of distress, better relationships, improved problem-solving and coping skills, and solutions to specific problems. Our therapists will do their best to make sure your child will have a positive therapeutic experience. However, therapy remains an inexact science and no guarantees can be made regarding the results. There are alternatives to counseling and therapy for addressing mental health issues. This includes consulting with your primary care physician for medical options or consulting with a spiritual leader in your community for spiritual options. You may also choose to not to seek any treatment. This option increases the risk of the current mental health issues becoming more difficult to cope with.

Sincerely,

Marie Capra  
Clinical Supervisor, Mental Health Counseling  
Minneapolis School Based Clinics

## Client Information

Client Name (first, last) – Please print \_\_\_\_\_

Client DOB (dd/mm/yyyy) \_\_\_\_\_

Client Student ID \_\_\_\_\_

### Part One: Limits of Confidentiality

As a general rule, the therapist will keep the information shared in therapy sessions confidential unless there is written consent signed by you or in some cases, your child, to disclose certain information. There are, however, exceptions to this rule that are important for you and your child to understand before personal information is shared in a therapy session. In some situations, therapists may be required by law or the guidelines of their profession to disclose information whether or not they have your permission.

Confidentiality cannot be maintained when:

- The client tells the therapist he or she plans to cause serious harm or death to themselves.
- The client tells the therapist they plan to cause serious harm or death to someone else.
- The client is doing things that could cause serious harm to them or someone else, even if they do not intend to harm himself or herself or another person.
- The client tells the therapist they are currently being abused - physically, sexually, or emotionally, or has been within the past three years.
- The client comes for an appointment under the influence of drugs or alcohol.

#### Communicating with parent(s) or guardian(s)

Except for situations such as those mentioned above, therapists will not tell parents or guardians specific things clients share in private therapy sessions unless the client gives consent.

### Part Two: Communicating with Other Adults

Sometimes the therapist may need to work with members of the school staff in order to coordinate services and provide the best quality care for your child. This may involve sharing limited but necessary information.

*I hereby authorize the School Based Clinic to release and request necessary information with (check all that applies):*

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> School Social Workers           | <input type="checkbox"/> Alcohol & Drug Technicians | <input type="checkbox"/> Family, Community and Truancy Liaisons |
| <input type="checkbox"/> School Counselors               | <input type="checkbox"/> Check and Connect Staff    | <input type="checkbox"/> School Psychologists                   |
| <input type="checkbox"/> Special Education Case Managers | <input type="checkbox"/> Teachers                   | <input type="checkbox"/> Other: _____                           |

*I understand I may cancel this authorization at any time by writing a note of cancellation and giving it to \_\_\_\_\_. When I give or cancel my authorization, it is effective from that day forward. This authorization expires; \_\_\_\_\_ I also understand this authorization is voluntary, that I will not be denied treatment if I refuse to sign and that I have right to receive a copy of this authorization.*



Signature \_\_\_\_\_

Date \_\_\_\_\_

### Part Three: Release and Consent to Audio/Video Recording

In an effort to improve our services we provide supervision and training through the use of video and audio recording. This method allows for the direct feedback and supervision of the therapist and improves the quality of service your child receives. Professionals involved in this supervision and training may include; supervisors, colleagues and graduate school professors.

All audio and video recordings are destroyed after they are no longer needed for the purposes stated above.

*I hereby give my consent to audio and video record therapy sessions with my child. I understand that these recordings are utilized exclusively for purposes of supervision and training, and that I can revoke this consent at any time by writing a note of cancellation and giving it to: \_\_\_\_\_ This authorization expires on: \_\_\_\_\_ I also understand this authorization is voluntary,*

*that I will not be denied treatment if I refuse to sign and that I have right to receive a copy of this authorization.*

Parent/Guardian Signature	Date	_____ Initial here if you Do Not wish your
Client Signature	Date	Child to be videotaped

**Part Four: Statements of Understanding and Written Acknowledgement of Consent for Treatment**

By signing this section, you are agreeing with the following:

1. I have read or talked to the therapist about:
  - a. What the procedures are and what will happen.
  - b. How they may help me/my child (the benefits).
  - c. How they might negatively impact me/my child.
  - d. The long-term effects the therapy might have.
  - e. Other choices for treatment.
  - f. What will likely happen if I say "no" to this therapy for my child.
  - g. How my child might feel right after sessions and what supports are available between sessions.
2. I agree that:
  - a. I and/or my child will ask questions.
  - b. No one has promised me or my child definite results.
  - c. Treatment goals are reviewed, and revised if necessary, every 90 days. Your child's therapist may want to discuss these revisions with you.
3. I understand that:
  - a. I can change my mind about my child receiving therapy. If I do, I must tell my therapist or team as soon as possible.
  - b. The therapist may change during the therapeutic term. (This is a rare occurrence).
  - c. My therapy services may be provided by telemedicine.
  - d. There are additional risks, benefits, and consequences associated with telemedicine mental health.
4. I agree to:
  - a. Give permission to the therapist to gain access to my child's school records
  - b. Participate in a diagnostic assessment and creation of a treatment goals and/or plan for my child if needed.
  - c. Give permission to the clinic to enter my child's service information in the confidential MN Kids data base for purpose of program evaluation.

*My signature below means that I understand and agree with all of the points above.*

Client Signature	Print Name	Date
Parent/Guardian Signature <i>if client is a minor</i>	Print Name	Date

Verbal Consent obtained: \_\_\_\_\_ Date: \_\_\_\_\_

*I, the practitioner/professional providing clinical services, have discussed the issues above with the client and/or parent or guardian of a minor client and answered their questions. The client and/or their parent/guardian provided informed consent to the above mental health services.*

Practitioner/Professional Signature	Print Name	Date
-------------------------------------	------------	------

### Part five: Consent to Participate in Evaluation

I give permission to:

1. Enter service information in the confidential MN Kids database for purpose of program evaluation.
2. Provide service information to Washburn Center for Children for purpose of reporting outcome measures to Minnesota Department of Human Services.

*I understand I may cancel this authorization at any time by writing a note of cancellation and giving it to School Based Clinic Manager. When I give or cancel my authorization, it is effective from that day forward. This authorization expires in 3 years. I also understand this authorization is voluntary, that I will not be denied treatment if I refuse to sign and that I have right to receive a copy of this authorization.*

*My signature below means that I understand and agree with all of the points above.*

\_\_\_\_\_  
Client Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date

\_\_\_\_\_  
Parent/Guardian Signature if client is a minor \_\_\_\_\_ Print Name \_\_\_\_\_ Date

Verbal Consent obtained: \_\_\_\_\_ Date: \_\_\_\_\_

*I, the practitioner/professional providing clinical services, have discussed the issues above with the client and/or parent or guardian of a minor client and answered their questions. The client and/or their parent/guardian provided informed consent to the above mental health services.*

\_\_\_\_\_  
Practitioner/Professional Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date

#### Client Information

\_\_\_\_\_  
Client Name (first, last) – Please print \_\_\_\_\_ Client DOB (dd/mm/yyyy) \_\_\_\_\_ Client Student ID

### Part Six: Billing/Payment Policy

Counseling and therapy are provided whether or not students have health insurance. The clinics will bill insurance whenever possible to help cover the cost of services; co-pays and deductibles will only be charged to those with private insurance. After we receive your insurance payment you will receive an email invoice with link to pay via a secure and private web site (payspan).

We really appreciate any payments that you can make. We will never send your account to any outside collection agency and do not want your inability to pay to in any way impact the care your teen receives from the School Based Clinic. If you have any questions, please feel free to contact the School Based Clinic Manager at 612-668-5305.

\*\*Insurance Provider/Payer ID: \_\_\_\_\_ Group ID: \_\_\_\_\_ Group Number: \_\_\_\_\_ Phone: \_\_\_\_\_

*I hereby authorize The Minneapolis Health Department School Based Clinics to release all billing and medical information regarding my diagnosis, treatment and substance abuse if applicable to any third-party payer, when such information is requested for payment utilization review or coverage determination purposes.* **Initial Here:** \_\_\_\_\_

I consent to receive invoices via encrypted email

Does your child have health insurance?  Yes  No

If you checked “No” your child may be eligible for free or low cost through MNSURE

Please check this box to get more information or assistance on obtaining health insurance for your child

I would like assistance with reviewing my child’s insurance

I consent to Portico Healthnet contacting me with more information.

Parent/Guardian Signature: \_\_\_\_\_ Email address \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_