

Client Information

Name		Gender M F	Date	
Address:			DOB	
			SSN	
Home Ph:	Cell Ph:	Other Ph:		Email
Parents			Ph:	
Contact #1			Ph:	
Contact #2			Ph:	
Living Situation				
TSC/ESC, Agency			Ph:	
Diagnosis: Code: IQ:				
Physician			Ph:	
			Fax:	
Psychiatrist:			Ph:	
			Fax:	
ST/ OT/ PT			Ph:	
			Fax:	
Other:			Ph:	
			Fax:	
Medicaid #:		HC#:		
Allergies:		Diet Restrictions:		
Special Medical Needs:				
School:			Ph:	
			Fax:	
Address:			Grade:	
Teacher/Contact		Grade:		

**Children's Therapy Place Inc.
EPSDT Service Coordination
Informed Consent/ Choice Form**

Client Name: _____ DOB: _____

Parent/Guardian Name: _____

Description of What a Service Coordinator Does:

1. Develop the Service Plan based on the needs of the child and make adjustments as needed throughout the year
2. Finding, arranging, and assisting you to maintain services, supports, and community resources, as identified on the Service Plan
3. Monitoring the IEP and attend school meetings upon request, including the IEP meeting
4. Demonstrate impartiality and recognize the family as primary decision makers unless otherwise exempted by the court
5. Advocating for unmet needs
6. Encouraging independence
7. Monitoring and coordinating services, including helping you to coordinate and retain service coordination
8. Assuring consistency and non-duplication between services
9. Assuring that services are satisfactory

Your Choices:

1. You or your parent/guardian may refuse service coordination services
2. Service coordination is an optional service
3. You may discontinue service coordination at any time
4. You may change service coordinators or agencies at any time, either by
 - a. Requesting a change in coordinators from your present agency
 - b. Contacting Health and Welfare at 334-0954 to request an agency change and/or a list of available agencies
 - c. Requesting that the new agency process the change application

I may choose a different service coordinator, but I select:

Name of Service Coordinator and Service Coordination Agency

My reason for selecting this particular person and agency is:

Signature: _____ Date: _____

Confidentiality Acknowledgement

Medicaid/ Insurance Policy: I request that payment of authorized Medicaid/insurance benefits be made to Children's Therapy Place on my behalf.

Health Insurance Privacy Accountability Act (HIPAA): Children's Therapy Place clients acknowledge that by signing this document, Children's Therapy Place may use identifying information about clients for the purpose of treatment, payment, and operation. Clients have the right to review all privacy notices before signing, have the right to requests and restrictions on disclosure, and have the right to revoke consent. Further information regarding HIPAA can be located under 164.520 of the IDAPA code.

Confidentiality Policy: Children's Therapy Place clients acknowledge that by signing this document, all client information written/verbal and client interactions will be confidential. Information will only be exchanged with other Children's Therapy Place employees or individuals with signed releases of information who are actively involved in treatment/services.

Exceptions to Confidentiality: There are exceptions to complete confidentiality with which Children's Therapy Place must comply. Some of these exceptions include child abuse, suicidal clients, Tarasoff 'duty to warn', joint custody decrees, Guardian Ad Litem, Crime Victim Compensation Program, and subpoenas. Children's Therapy Place is required to report to the appropriate authorities when any of these circumstances are disclosed or present themselves.

Appointment Policy: All scheduled appointments must be kept or cancelled 24 hours in advance. If there are 3 missed appointments (no call prior to the scheduled appointment or no show) during the course of service, a client's services will be subject to discontinuation. A 30-day notice of possible discontinuation will be sent.

Payment is expected at the time of service, when applicable.

By my signature below, I affirm that I have read or have had explained to me the 'Confidentiality Acknowledgement' of Children's Therapy Place. My signature also confirms that I have had a chance to review and discuss the 'Confidentiality Acknowledgement' with an employee of Children's Therapy Place and that I have received a copy of the 'Confidentiality Acknowledgement'.

Client Signature

Date

Legal Guardian/Representative Signature

Date

Agency Representative Signature

Date

Statement of Client Rights

Among the rights guaranteed under IDAPA 16.04.11.760 and Idaho Code Section 66-412 and 66-413 are the following:

1. You will not lose any legal rights because you are a client of Children's Therapy Place.
2. It is assumed you are legally competent beginning with your 18th birthday unless you have been determined otherwise by a court of law.
3. You have the right to exercise all civil rights, unless limited by prior court order, and you have all other rights established by law.
4. You have the right to adequate, courteous and humane services and care in the least restrictive environment; and to receive services which enhance your social image and personal competencies and, whenever possible, promote inclusion in the community.
5. You have the right to privacy, to communicate by telephone or mail, and to receive visitors to all reasonable times and associate freely with persons of your own choice.
6. You have the right to practice your own religion, wear your own clothes, and keep and use your personal possessions.
7. You have the right to refuse to perform services for Children's Therapy Place. If you are hired to perform services, Children's Therapy Place will pay you a wage consistent with state and federal law.
8. You have the right to be informed of your medical and habilitative condition, of services available at Children's Therapy Place, and the charges for the services.
9. Your service plan will be reviewed by you and approved by you. A qualified professional staff member will ensure that the treatment plan is implemented.
10. You have the right to refuse services EXCEPT if such services are to prevent serious harm to yourself or others.
11. You have the right not to be mentally, physically, or verbally abused, corporally punished or neglected.
12. You have the right not to be secluded or mechanically restrained without the convening of a treatment committee as specified in the Children's Therapy Place Policy and Procedures and this can only occur to prevent you from causing physical harm to yourself or others.
13. You have the right to emergency medical services and to be informed of your medical condition.
14. You have the right to receive a response to any request from Children's Therapy Place, in a reasonable time frame, and the right to voice grievances and recommend changes in policies and/or services being offered.
15. You have the right to review the results of the most recent survey conducted by the department and the accompanying plan of correction.
16. Information in the Children's Therapy Place records is confidential and will not be shared with others without your consent or the consent of the person responsible for you. You will also have reasonable access to your own records.
17. If you believe any of your rights have been violated, the accompanying grievance procedure provides you a method to have your complaint(s) reviewed.

Protection and Advocacy

People with various disabilities are entitled to protection and must have access to advocacy in securing the benefits, services, and rights to which they are entitled. The following are resources, which persons with developmental disabilities may call upon:

Advocacy:

Coalition of Advocates for the Disabled Inc.

Association of Retarded Citizens (ARC)

NAMI

Legal Aid Services, Inc.

Private Attorneys

Family members or friends

Regional Mental Health Authority

Idaho Parents Unlimited (IPUL)

Protection:

Adult Protection Services

Law enforcement agencies

A current and complete list of advocacy and protection services including telephone numbers and addresses can be obtained from Children's Therapy Place.

By my signature below, I affirm that I have read or have had explained to me all my rights as a client of Children's Therapy Place. My signature also confirms that I have had a chance to review and discuss each right listed above with an employee of Children's Therapy Place and that I have received a copy of the 'Statement of Client Rights'.

Client Signature

Date

Legal Guardian/Representative Signature

Date

Agency Representative Signature

Date

**CHILDREN'S THERAPY PLACE INC.
AUTHORIZATION FOR DISCLOSURE**

Client Information

Client Name _____ Date of Birth _____

Mailing Address _____ State _____ Zip Code _____

Requestor Information to be completed if authorization is being made by someone other than the subject of the information.

Requestor Name _____ Jacque Graven-Polowski _____ Telephone 323-8888

Relationship _____ Service Coordinator _____

Address 6855 W Fairview Ave Ste 120, Boise _____ State _____ ID _____ Zip 83704

Authorization Details

I authorize the following

To disclose this confidential information to Children's Therapy Place _____

Address 6855 W Fairview Ave Ste 120, Boise ID 83704 _____

Fax 323-8889 _____ Phone 323-8888 _____

For the purpose of Service Coordination _____

Please describe in detail the information to be disclosed

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization.

Your signature _____

Date _____