

Client First, Last Name: _____

Client Date of Birth: _____

CONSENT FOR TREATMENT AND SERVICE AGREEMENT

This document records consent for treatment and outlines the conditions under which services are provided by Child and Family Agency of Southeastern Connecticut (CFA).

CONSENT FOR TREATMENT

Client/Person to Receive Services at CFA

Client First Name _____

Client Last Name _____

Date of Birth (MM/DD/YYYY) ____/____/____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ ZIP Code _____

Person Providing Consent to Treatment (Select one)

- ☐ I am 13 years of age or older and am requesting and consenting to receive services. The information above is my own.
- ☐ I am 18 years of age or older and am requesting and consenting to receive services. The information above is my own.
- ☐ I am the parent/legal guardian of a minor requesting/receiving services and have the legal authority to consent to treatment. My information is provided below:

Parent/Legal Guardian First Name _____

Parent/Legal Guardian Last Name _____

Relationship to Client (select one): **Parent/Legal Guardian** **Other(specify):** _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ ZIP Code _____

SCHOOL BASED HEALTH CENTER OPT IN

CFA's School-Based Health Center (SBHC) programs provide medical and/or mental health services at the following locations for school-aged clients.

To register the school-aged client, please select their school and provide their current grade. If not interested in SBHC services, no action is required. You may proceed to the next page.

School Aged Client School:

- ☐ Bennie Dover Jackson Middle School (New London)
- ☐ BP Mission (Early Childhood Center)
- ☐ Catherine Kolnaski STEAM Magnet School (Groton)
- ☐ C.B. Jennings International Elementary Magnet School (New London)
- ☐ CFA Early Childhood Development Center (New London & Groton)
- ☐ Dean's Mill Elementary School (Stonington)
- ☐ Dr. Charles G. Barnum School (Groton)
- ☐ Ella T. Grasso Technical School (Groton)
- ☐ Fitch High School (Groton)
- ☐ The Friendship School (Waterford)
- ☐ Gales Ferry School/Juliet W. Long School (Gales Ferry/Ledyard)
- ☐ Gallup Hill School (Ledyard)
- ☐ Groton Middle School (Groton)
- ☐ Ledyard High School (Ledyard)
- ☐ Ledyard Middle School (Gales Ferry/Ledyard)
- ☐ Mary Morrisson (Early Childhood Center)
- ☐ Mystic River Magnet School (Groton)
- ☐ Nathan Hale Arts Magnet School (New London)
- ☐ New London High School (New London)
- ☐ Northeast Academy (Groton)
- ☐ Regional Multicultural Magnet School (New London)
- ☐ Stonington High School (Pawcatuck)
- ☐ Stonington Middle School (Stonington)
- ☐ Thames River Magnet School (Groton)
- ☐ West Vine Elementary School (Pawcatuck)
- ☐ Winthrop STEM Magnet Elementary School (New London)
- ☐ Not interested in SBHC services at this time

School Aged Client Grade: _____

SERVICE CONDITIONS AND EXPECTATIONS

By consenting to treatment for myself or the client, I understand that:

☐ **Services Provided**

- Services are individualized based on the client's needs, clinical or medical assessment, and program eligibility.
- Services may include individual therapy, family therapy, group therapy, psychiatric evaluation, outpatient medical services, school-based medical services, psychiatric medication management, and/or non-clinical community programs.
- Services may be provided in person, through telehealth, in the community, in schools, or in the home depending on program availability and clinical need.
- When telehealth services are provided, the client must be physically located in the state of Connecticut.

☐ **Confidentiality**

- I understand that confidentiality and privacy practices are explained in CFA's Client Rights and Responsibilities and Notice of Privacy Practices documents.
- When services are provided outside of a CFA office, conversations may be overheard by individuals who are not participating in treatment. While CFA will make reasonable efforts to protect privacy, complete confidentiality cannot be guaranteed in these settings.

☐ **Safety and Mandatory Reporting**

- CFA staff are mandated reporters. In the event of suspected abuse or neglect, staff will seek supervisory input and may be required to file a report with child protective services or seek emergency intervention to ensure the safety of the client or others.

☐ **Emergency Procedures**

- CFA administrative offices are open Monday through Friday, 8:30 a.m. to 4:30 p.m. Clinical service hours vary by program. Current clients have access to 24/7 on-call support for urgent concerns by calling (860)440-7182. In a life-threatening emergency, call 911.
- If emergency medical treatment is necessary for a client under the age of 18, CFA staff will attempt to contact the parent/legal guardian and may call 911 when necessary to protect the health and safety of the client or others.

☐ **Appointment Expectations**

- Clients are expected to attend scheduled appointments and participate in treatment in accordance with the Client Rights and Responsibilities Agreement. Please refer to that agreement for the full description of client responsibilities and expectations related to participation in treatment.
- For clients under 18, parents/legal guardians may be required to be available during the duration of the appointment or asked to participate in treatment sessions when deemed clinically necessary by the provider.

- For clients under 12 years of age, a Parent/Legal Guardian is required to remain available for the duration of the appointment to provide support and assistance as needed. This requirement does not apply to appointments held at SBHCs.
- If a client becomes uncomfortable during a session they may stop the session at any time, and if under the age of 18 may access their parent/legal guardian.

- **School Based Health Center Services**
 - Do not replace the client's regular community primary care provider. If a client does not have a primary care provider, staff will assist them with a referral to a primary care medical home.
 - If opting in I consent that the client specified can obtain routine health services at a CFA SBHC, including annual recommended screenings and preventative visits.
 - I authorize CFA to exchange information as needed with the client's primary care provider, school nurse, and key school district personnel to effectively care for the client. I understand that the SBHC medical and behavioral health providers may communicate with one another about client care.
 - I understand that my child will continue to be enrolled in a CFA SBHC if child is enrolled in a school that has a CFA SBHC, although yearly updates will be requested.
 - I recognize that health records, if received by the school district, may not be protected by the HIPAA Privacy Rule, but will be education records protected by the Family Education Rights and Privacy Act.

- **In Home and Crisis Services**
 - For in-home services, a parent/legal guardian or another responsible adult (18 years of age or older) who resides in the home must be present.
 - For in-home services, clients shall to the best of their abilities provide a safe environment for sessions to be completed, in alignment with CFA's Client Rights and Responsibilities.
 - For the Urgent Crisis Center, a parent/legal guardian must accompany all minors under 18 years of age.

Authorization for Electronic Communications

By checking the box and providing the contact information, I agree and consent to communications regarding services at CFA in the following forms:

- ☐ Home phone _____
 - ☐ Phone Call
 - ☐ Voicemail
- ☐ Parent/Legal Guardian Work phone _____
 - ☐ Phone Call
 - ☐ Voicemail
- ☐ Parent/Legal Guardian Cell Phone: _____
 - ☐ Phone Call
 - ☐ Voicemail
 - ☐ Text Message
- ☐ Parent/Legal Guardian Email: _____
- ☐ Client/Person Receiving Services (13+ only) Cell Phone: _____
 - ☐ Phone Call
 - ☐ Voicemail
 - ☐ Text Message
- ☐ Client/Person Receiving Services (13+ only) Email: _____

Clients/Person receiving services and parents/legal guardians can withdraw consent to electronic communications at any time verbally or in writing.

CONSENT FOR TREATMENT AND SERVICE AGREEMENT ACKNOWLEDGEMENT AND SIGNATURES

By signing below, I voluntarily consent (or authorize the named client) to receive services provided by CFA. I acknowledge that I have reviewed, understand, and agree to CFA's Service Conditions and Expectations as outlined in this document.

Client/Person to Receive Services Signature (if 13 years of age or older)

Date (MM/DD/YYYY)

Printed Name (First & Last)

Signature

Parent/Legal Guardian Signature (if applicable)

Date (MM/DD/YYYY)

Printed Name (First & Last)

Signature
