CHILDREN'S HEALTH COUNCIL

650 Clark Way Palo Alto CA 94304
Main phone # 650.326.5530
www.chconline.org

CONSENT TO TREAT and DISCLOSURE STATEMENT

Child's Name ____ ID# ______________

Clients and legal guardians consent to receive assessment and treatment services at The Children's Health Council (CHC) which shall be defined to include any and all medical doctors, psychologists, therapists, educators, and postdoctoral therapists or psychologists in training and all related staff members. Clients and legal guardians consent to enter into the following understanding:

1. Clients will be administered diagnostic and treatment procedures recommended by the professional staff. A parent or legal guardian must initial numbers 6, 11 and 12 in the following in order to acknowledge payment responsibility and /or to be contacted to participate in CHC research. In the case of joint custody, both parents will need to initial, sign and date this document. If both signatures are not present on this document your child will not be seen.

2. The CHC may recommend intelligence testing as part of an assessment. Intelligence tests provide valuable information in regard to intellectual strengths and weaknesses. This information shall be interpreted in the context of a child's sociocultural and individual uniqueness to minimize biases and limitations inherent in any standardized testing.

3. The CHC is hereby authorized to communicate with the physician or practitioner who made the referral for the assessment or treatment services.

4. Depending on the client's clinical needs, assessment and treatment services may be provided by one or more clinical, educational or behavioral staff member. All oral or written information contained in medical and historical records will be confidentially maintained. Various staff members including trainees will have access to all of the client's records. Information or conclusion data may be used to evaluate CHC services and programs for quality assurance. Without identifying any individual client information, CHC may use data for presentations, publications or outcome research purposes.

5. CHC is an accredited training institution and maintains a specialist program for pre and postdoctoral psychologists and masters level therapists. CHC also serves as a training rotation for child psychiatry residents and fellows from Stanford University. Training staff may participate in the care clients receive at CHC. Confidential information is shared with a senior practitioner for clinical supervision.

6. The information provided during assessment and treatment services is confidential. Specific information is released to outside agencies or persons only after written consent of a parent(s) or legal guardian(s) is obtained. The only exceptions to confidentiality are as follows:
- When a client, family member or collateral person states an intention to seriously harm him/herself or, harm another person(s). CHC has the legal obligation to warn the individual's family, intended victim, and/or the police.
- When there is reason to believe there is abuse or neglect of a child or vulnerable adult. The law requires a report be made to the police or other appropriate county agency.
- When an emergency condition occurs, CHC will communicate with a family member or other appropriate person.
- By court order.
- When a joint custodial parent requests information about their child. Information that is not necessary to the assessment or treatment of the child will remain confidential in regard to the other (custodial) parent.

7. A minor has the right to request private data be kept from their parents or legal guardian. This request will be honored by CHC if it is believed to protect a child from physical or psychological harm, or if confidentiality is in the best interest of the child. However, parents and legal guardians have a right to information regarding their child, and efforts will be made to engage families as partners in assessment and treatment services.

8. If any child is the subject of a court order, settlement or custody agreement, the parents or guardians must furnish CHC with a copy of the order or agreement by the parent or guardian who has been awarded or granted legal custody of the child. If two separate or divorced parents share legal custody, or if two guardians are appointed by a court, then all requests for information or all consents for treatment, or a plan for treatment must be approved by both parents with legal custody or both by guardians appointed by the courts. The person or party who has obtained or agreed to the custody modification or change shall furnish CHC with any modification or change of legal custody or guardianship of the child. A child will not be seen unless this information is provided. Any information relevant to the child's assessment or treatment learned during a child's treatment may be included in reports and medical records.

9. Individuals and families have the right to access clinical information. You may request an information review with a CHC practitioner. However in certain circumstances, if a CHC practitioner determines that reviewing such information may be deemed harmful, the practitioner may instead provide a summary of the clinical information. Alternatively an outside therapist can be requested by a parent/guardian to interpret the information after a specific release of information is obtained. Copies of medical records can be requested at an additional expense.

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10. CHC gathers information from the children and families served, to assist in meeting our objectives and goals through studies by internal and external researchers. By initialing this, CHC is authorized to release your name and telephone number to research personnel. A researcher authorized by CHC may initiate contact in the future. The caller may extend the opportunity for you to participate in new or ongoing research, however in no way are you obligated to participate. Please initial one of the following two statements.

- I grant consent to contact: Parent 1 Initial ______ Parent 2 Initial ______
- I do not grant consent to contact: Parent 1 Initial ______ Parent 2 Initial ______

11. Fees, contracts, grants and financial assistance funds support CHC services and programs. A CHC business office representative may meet with you to provide an estimate of service and program cost and discusses financial arrangements. Fees for services are expected to be paid on or before the first date of service for assessment and treatment services, unless special grants, programs or contracts fund the services. Groups and classes are expected to be paid in full, by the month or series. As an accommodation, CHC will bill health insurance plans on your behalf, which will include the transmission of confidential diagnostic information. If you do not authorize CHC to communicate confidential diagnostic information, then CHC will not communicate with your insurance company. CHC will not accept assignment of payment and does not in any way guarantee insurance eligibility, authorization or level of reimbursement. You are personally responsible for the cost of any services incurred at CHC.

- Parent 1 Initial: ______ Parent 2 Initial: ______

12. Scheduled appointments require a 24-hour cancellation notice. If notice is not received for a treatment service, you will be billed the practitioners' hourly rate. If notice is not received for a team assessment appointment, you will be billed for that individual service in addition to the previously agreed upon assessment package charge. No refunds will be credited for individual session absences to groups or classes. It is the client's responsibility to be on time for each and every appointment or session. If a client arrives late for any appointment or session, the appointment or session will end at the appointed time.

- Parent 1 Initial: ______ Parent 2 Initial: ______

13. CHC will make its best efforts to safeguard children and families while receiving services. However CHC is not responsible for accidental injuries and assumes no liability for injuries occurring without fault or negligence of any member of the staff.

14. In the case of an emergency, when it is the opinion of the professional staff that a child be seen by a physician, and it is not possible to reach parents or legal guardians, or the child's primary care physician, an emergency arrangement will be initiated by a CHC staff member for the child to receive treatment.

Primary Care Physician
Name ______________________________
Address & Phone ______________________________
Health Agency Name ______________________________

Emergency Contact:
Name ______________________________
Address & Phone ______________________________
Relationship to Child ______________________________

By signing below, I agree to the terms and conditions outlined above and authorize CHC to provide assessment and treatment services to my child and/or family. I also agree to be financially responsible for those services.

Child's Name ______________________________ ID# ________________
(Please print)

Parent/Guardian ______________________________ Date _______________
(Signature)

Parent/Guardian ______________________________ Date _______________
(Signature)