KidsTLC
Outpatient Behavioral Health
620 South Rogers Road
Olathe KS 66062
913-234-3823 phone 913-324-3890 fax

Client Full Name: | Today's Date:

Referral Source:

Client Information (Please Print Legibly)

Address:

City: State: Zip:

Client Phone (if applicable): | Client Email (if applicable):

OK to call?: ☐Yes ☐ No OK to text?: ☐Yes ☐ No OK to leave a message?: ☐Yes ☐ No

Client Social Security #: Client DOB: Sex: ☐M ☐F Gender Preference: ☐M ☐F

Household Income (estimated): Size of Household Unit:
Language Preference:

Check one: Ethnicity ☐American ☐Mexican ☐European ☐Asian ☐Canadian ☐Other_____

Check one: Race __Hispanic __Multi-Racial __Black/African American __Caucasian/White __American Indian __Asian/Pacific Islander ___Other_____

Parent/Guardian Information

Full Name: | Relationship to Client:

Home Phone: Cell Phone: | Preferred Phone: ☐Home ☐ Cell

Email:

OK to call?: ☐Yes ☐ No OK to text?: ☐Yes ☐ No OK to leave a message?: ☐Yes ☐ No

Name of Employer: | Occupation:

How do you prefer to be reached? ☐Phone ☐ Email | Best time to contact you?

Where did you first hear about us?

Client Primary Insurance

Primary Insurance: | Insurance ID#:

Insurance Group #:

Insurance Subscriber: | Subscriber D.O.B.:

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Other:

Subscriber Address (if different):

Secondary Insurance

Secondary Insurance: Insurance ID #:

Insurance Group #: | | |

Insurance Subscriber: | | Subscriber D.O.B.:

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Other:

Subscriber Address (if different):

Please check one:
_____I understand that my insurance company will be billed at the full cost for services provided.
_____Client is not covered under any healthcare plan.
_____Client has healthcare insurance but does not wish services to be billed to them. This constitutes Full Fee for Services based on Private Pay Rate

Acknowledgement

The above information is true to the best of my knowledge. I understand I am responsible to provide Kidstlc with any updates and/or changes to my insurance coverage or change of address.

Responsible Party Signature | Date

Outpatient Behavioral Health Program

Notice of Privacy Practices

Privacy is a very important concern for all those who come to KidsTLC for service. It is also complicated because of federal and state laws and our profession. Because the rules are so complicated, some parts of this Notice are quite detailed and you probably will have to read them several times to understand. If you have any questions our staff will be happy to help you.

Contents of this Notice

A. INTRODUCTION TO OUR CLIENTS

This notice will tell you about how we handle information about you: how we use this information in our office, how we share it with other professionals, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself. We are also required to tell you about this because of the privacy regulations of a federal law, the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996 (**HIPAA**).

B. WHAT WE MEAN BY "YOUR INFORMATION"

As we work with you and/or your family, we are collecting information about you. Much of this information is related to your physical, medical, educational, emotional, and mental health status from the past, present, or future. Information can also relate to payment for services provided. This **P**rotected **H**ealth **I**nformation (**PHI**) is likely to include:

- ✓ Referral reasons, strengths, needs, goals, progress toward goals, past allegations/charges/convictions, and/or diagnosis.
- ✓ Information/history about your family which you, they, or your referral source provide.
- ✓ Treatment plans.
- ✓ Records we get from others who treated, evaluated or provided care for you or you your family members.
- ✓ Reports generated at regular intervals that provide an update of your well-being and treatment progress.
- ✓ Individualized notes that clinicians/therapists make after every contact with you that describe what was discussed and observed.
- ✓ Reports on incidents that have occurred with you such as injuries, illness, behavior or conduct concerns, or allegations of abuse or neglect.
- ✓ Insurance billing information.
- ✓ Legal documents, as applicable.
- ✓ Consents you or your family have signed for us to share specific information to aid your treatment.
- ✓ Reports or assessments which help guide treatment and referrals.

The above list is not comprehensive; there may be other kinds of information that goes into your file.

Although the clinical record is the physical property of KidsTLC the information belongs to you. With the guidance of a KidsTLC staff member, you can inspect, read, and review it. There are limits of what information we can share with you and your request will be honored within a reasonable time frame based on the information you are requesting to review. If you find anything in your records that you think is incorrect or something important is missing you can ask us to amend it, although in some situations we don't have to agree to do that.

C. PRIVACY AND THE LAWS

The HIPAA law requires us to keep your information private and to give you this notice of our legal duties and our privacy practices, which is called the Notice of Privacy Practices (NPP). We will obey the rules of this notice as long as it is in effect but if we change it, the rules of the new NPP will apply to all the information we keep. If we make changes, we will post the new Notice in our office.

D. HOW YOUR PROTECTED HEALTH INFORMATION CAN BE USED AND SHARED

When professionals within KidTLC's agency read or utilize your information, the law terms this, "**use.**" When your information is shared with or sent to persons outside this agency, that is termed, "**disclosure.**" Except in some special circumstances, when we use your protected information here or disclose it to others we share only the **minimum amount of information necessary** needed for the purpose. The law gives you rights to know about your information, how it is used, and to have a say in how it is disclosed.

1. Uses and Disclosures of Information with Your Consent

You or parents or legal guardian will be asked to sign a separate **Consent form** to allow us to use and share only the minimum necessary. You or your parents or legal guardian must sign the Consent Packet before we begin services; without consent, we are unable to serve you/your family at KidsTLC. If you are in state custody and the Court has determined that a department (DCF or JJA) of the state has legal custody of you, the state department responsible for your care can provide this permission and sign the Consent Packet. Our preference is that you and/or your parents co-sign these documents also. In almost all cases we intend to use your information internally or share your information with people or organizations external to KidsTLC to provide **Treatment** to you, arrange for **Payment** for our services, or conduct health care **Operations** (providing needed safety information). Together these routine purposes are called **TPO** and your guardian's signature on the Consent form allows us to use and disclose TPO information. Please re-read that last sentence until it is clear because it is very important.

1a. For Treatment, Payment or Health Care Operations:

For Treatment. We use or disclose your information to provide you and/or your family with the services needed and identified in your case plan/treatment plan.

With consent, we may share or disclose your information on a **minimum necessary** basis to others who are considered to be part of the larger treatment team and who may provide treatment/services for you and/or your family, such as your personal physician, psychiatrist, school or educational personnel, therapist, or foster care/residential provider. Again, this information will be on a minimum necessary basis for the professional to determine if they can provide needed treatment and services. Once the service/treatment provider has agreed to provide care and treatment, the provider becomes part of the team and more information may be shared to and from team members to ensure all professionals are working collaboratively together in the best interest of you and and/or your family. All disclosures will be documented in your file.

For Payment. We may use or disclose your information to bill your parents' private insurance, client medical card, you parents' directly, or the State of Kansas (SRS or JJA) for services provided. We may contact the payee to check on exactly what your insurance covers. We may have to tell the payee about the dates you have been at KidsTLC, your diagnoses, what treatments have been received, and what we expect as we continue treatment. Minimum necessary information may be provided to a collections agency if we must use one to secure payment for services rendered.

For Health Care Operations. There are some other ways we may use or disclose your information. We may use or disclose your information to see where we can make improvements in the care and services that we provide. Examples of how we do this are through data collection and case file audits. We may be required to supply some information to government agencies and referring agencies so they can evaluate the quality of TLC's service and treatment. In these cases, involved parties sign an agreement not to disclose any information they read about, and are provided with the minimum necessary information to conduct their reviews. Reports on aggregate groups (no identifying information)

may be provided to stakeholders, consumers, funders, or other bodies to show how staff are performing or to demonstrate that clients are getting services they need from KidsTLC.

1b. Other Uses in Healthcare

Phone Calls and Written Correspondence. We may use and disclose your family's personal information (such as address or phone number) to reschedule or provide reminders of appointments, notify parents of incidents, request historical information for treatment or other care. If you don't want us to call or write your family at a certain location, you must let us know. We can generally try to arrange for that.

Treatment Alternatives/Benefits. We may use and disclose your information to tell you about or recommend possible treatment or alternatives, health-related benefits, or services that may be of interest to you.

Research. We may use or share your information to do research to improve treatments. In all cases your name, address, and other information that reveals who you are will be removed from the information given to researchers. If they need to know who you are we will discuss the research project with you and you will have to sign a special Authorization form before any information is shared.

Business Associates. There are some jobs we hire other businesses to do for us. The law terms these individuals, "Business Associates." Examples might include agencies that complete financial audits, shred documents, transport youth, or lawyers. These business associates may need to receive some of your information to do their jobs properly. To protect your privacy they have agreed in their contract with us to safeguard your information.

2. Uses and Disclosures Requiring Your Authorization

If we want to use your information for any purpose besides treatment, payment, and other benefits/services, or those we described above we need you or your parents' or legal guardian's permission on an Authorization form. We don't expect to need this very often.

If you or your parents or legal guardian authorize us to use or disclose your information, you or your parents or legal guardian can cancel that permission, in writing, at any time. After that time we will not use or disclose your information for the purposes that we agreed to. Of course, we cannot take back any information we had already disclosed with permission or that we had used in our office.

3. Uses and Disclosures of Information from Clinical Files not Requiring Consent or Authorization

When required by law. There are some federal, state, or local laws, which require us to disclose information.

- ✓ We have to report suspected child abuse or neglect.
- ✓ If you are involved in a lawsuit or legal proceeding and we receive a subpoena, discovery request, or other lawful process we may have to release some of your information.
- ✓ We have to disclose some information to the government agencies, which check on us to see that we are obeying the privacy laws or with which we have a contract to provide services.

For Law Enforcement Purposes. We may release information if asked to do so by law enforcement officials to investigate a crime or criminal.

For public health activities. We might disclose some of your information to agencies, which investigate disease or injuries.

For specific government functions. We may disclose information of military personnel and veterans to government benefit programs relating to eligibility and enrollment, to Workers' Compensation programs, to correctional facilities if one of your parents or legal guardian is an inmate, and for national security reasons.

To Prevent a Serious Threat to Health or Safety. If we come to believe that there is a serious threat to you or you and/or your family's health or safety or that of another person or the public we can disclose some of your information. We will do this to persons who can prevent the danger.

4. Uses and Disclosures Requiring You to have an Opportunity to Object

We can share some information about you with you and/or your family or close others. We will only share information with those involved in your care and anyone else your parents' choose (if you are a minor) such as close friends, your mentor, or clergy (i.e. locating kinship placement). We will ask you about whom you want us to tell what information about your situation or treatment. You can tell us what you want and we will honor your wishes as long as it is not against the law.

If it is an emergency and we cannot ask if you disagree we can share information if we believe that it is what you would have wanted and if we believe it will help you if we do share it. If we do share information, in an emergency, we will tell you as soon as we can. If you don't approve we will stop, as long as it is not against the law.

5. An Accounting of Disclosures

When we disclose your information we will keep some records of who we sent it to, when we sent it, and what we sent. You can get an accounting of many of these disclosures.

E. IF YOU HAVE QUESTIONS OR PROBLEMS

If you need more information or have questions about the privacy practices described above, please speak to the Privacy Officer whose name and telephone number are listed below. If you have a problem with how your information has been handled or if you believe your privacy rights have been violated, contact the Privacy Officer. You have the right to file a compliant with KidsTLC and with the Secretary of the Federal Department of Health and Human Services. We promise that we will not in any way limit your care or take any actions against you if you complain.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer, the Program Manager. You can reach this person at 913-324-3682.

A copy of this notice is to be provided to all parent and legal guardians. Additionally, it is to be posted in a public location in the house and made available to all youth and employees at their request.

Consumer Rights & Responsibilities Acknowledgement

Professional Standards. The right to receive services in accordance with standards of professional practice, appropriate to consumer needs, and which are meant and designed to give the consumer reasonable opportunity for improvement. This includes being informed of the qualifications of KidsTLC staff that are providing services. The provision of services shall be responsive to each person's age, gender, social supports, cultural orientation, psychological characteristics, sexual orientation, physical situation, and spiritual beliefs. Additionally, all consumers have the right to be treated in a manner which is ethical and free from abuse, discrimination, mistreatment, and/or exploitation.

Treatment Plan Involvement. The right to participate in the development and review of your treatment plan, including known effects of receiving or not receiving such treatment and alternative treatment as may be available. Consumers have the right to have family members and/or members of one's support system participate in their ongoing treatment. Consumers have the right to receive an explanation of all medications prescribed and possible side effects. All consumers have the right to object to, or terminate treatment.

Confidentiality. The right to confidential maintenance of information about yourself and treatment received. We may not tell a person outside this agency that you attend our programs or discuss any information identifying you as a client receiving our services (including service records) without your written authorization or as allowed by law (including court orders, medical emergency, program evaluation by Center staff, suspected abuse or neglect, to report a crime or a threat to harm someone, etc.). Suspected violations of these confidentiality requirements may be reported to appropriate authorities in accordance with federal regulations. Records are protected by confidentiality and will not be revealed to anyone without prior written authorization & consent by the consumer unless otherwise outlined in accordance with state and federal laws.

Access to Records. The right to inspect your own record in the presence of your primary therapist and, as determined in KidsTLC's policies, the right to have a summary of your own record or copies sent to a coordinating provider, at your expense.

Least Restrictive Setting. The right to receive treatment in the least restrictive setting of the Managed Care Continuum that responds to your treatment needs.

Right to Request a Different Therapist: The right to request a different therapist at any point throughout the treatment process. This right may be restricted if you are an involuntary referral to counseling, or if there are limited agency resources to respond to your request
Freedom of Spirituality and Religion. The right to practice and express the religion &/or spirituality of your choice or to abstain from religious&/or spirituality practices, including as related to your treatment.
Constitutional/Civil Rights. The right to exercise constitutional, statutory, and civil rights, except those denied or limited by court action. No person shall, on the grounds of race, religion, ethnicity, color, national origin, ancestry, age, handicap, or sexual preference, be excluded from participation in, be denied the benefit of, or be otherwise subjected to discrimination under any program or activity of KidsTLC in the provision of its services.
Access to Information. The right to access information in sufficient time to facilitate your decision making.
Informed Consent. The right to have informed consent, refusal, or expression of choice regarding: 1) the delivery of services; 2) release of confidential information; 3) any concurrent services; or 4) the composition of your treatment team.
Copy of Rights. The right to receive a copy of the Client Rights Statement upon your request.
Legal Counsel. The right to contact or consult with legal counsel of your choice at your own expense.
Consumer Advocate: Questions, Concerns, or Grievances. The right to have questions answered or make complaints about services received as well as reporting a violation of consumer rights. Any consumer's question, concern, or grievance will not result in any retaliation or barrier being placed on them in order to access services.
Protection From Abuse. The right to humane care and protection from harm. Staff are prohibited from any use of psychological abuse, including humiliating, threatening, and exploiting actions. All instances of abuse or neglect of an adult should be reported to Adult Protective Services Unit (Adult Abuse Hot Line) at 1.800.992.6978. Circumstances of child abuse and neglect should be reported to Kansas Department of Social and Rehabilitation Services (SRS) at 1.800.922.5330
Location Accessibility. To receive services in a barrier-free location (accessible)
Communication Accommodations. To be communicated to, orally and in writing, in the languages of major population groups served at KidsTLC. To be provide or arrange for a certified interpreter/translator and translated material if necessary. To be provided with telephone amplification, sign language services, or other communication methods for deaf or hearing impaired individuals. To be provided or supported in the arrangement for communication assistance for persons with special needs who may have difficulty making their service needs known with consideration to the individual's literacy level. To request information about names, location, phones, and languages for local agencies.
Applicable Fees & Payment Responsibilities. All consumers have the right to be informed prior to treatment, about any and all applicable fees, estimated or actual expenses including the amount that will be charged when fees or co-payments are charged, changed, refunded, waived, or reduced; the manner and timing of payment; and the consequences of non-payment may result in necessary information being provided to a collection agency.
Consumer Conduct & Responsibilities. All consumers shall conduct themselves in an appropriate manner. Rule violations may lead to a limitation or termination of service. In some cases the police may be called. Visitors and staff shall not: 1) carry or be under the influence of intoxicating beverages or illegal substances; 2) steal, attempt to steal, or deface property of KidsTLC, staff, or visitors ; 3) assault or sexually harass anyone; 4) possess firearms or dangerous weapons; 5) threaten, intimidate, coerce, or interfere with other people; 6) falsify information provided to KidsTLC; 7) smoke inside any KidsTLC facility or on KidsTLC Campus. Services may also be limited or terminated if a consumer fails to keep their scheduled appointments.
Reinstatement. If your services have been limited or terminated, you may request a review of the situation and reinstatement of those services from the Clinical Manager. The Clinical Manager will provide you with information about if and how reinstatement can occur based upon the circumstances of the restrictions.

Consumer Responsibilities – Please read carefully

You are responsible for following all rules and regulations.

If you do not understand a rule or regulation you are responsible for seeking clarification as soon as possible.

You are responsible for providing the agency and your therapist with all possible information related to your physical or mental health.

You are responsible for actively participating in your treatment, including:
a. Asking questions to ensure you fully understand your treatment plan.
b. Communicating respectfully if you disagree with any of your treatment plan.
c. Actively participating in the development of your treatment plan.
d. Informing staff if you wish to cease any part of your recommended treatment plan.
You are responsible for not discriminating against other residents and staff by behaving in a way that is prejudiced or discriminating. (I.e. using discriminatory language, making fun of someone, etc)

You are responsible for letting staff know if you feel like your rights have been violated, using KidsTLC's Outpatient Behavioral Health Program Grievance Protocol.

You are responsible for respecting the property and privacy of other clients, staff and visitors, and for showing consideration for others with respect to noise and disruption.

You are responsible for all fees applicable including fees that are not covered by an insurance company, Medicare, or Medicaid. Consequences of non-payment may result in necessary information being provided to a collection agency.

If applicable, all consumers are required to report if their insurance coverage has changed.

You are responsible for respecting the privacy of others

You are responsible for letting a staff member know if you have difficulty reading or if you require communication accommodations, so that we can assist you in understanding your rights, responsibilities, and other information.

Grievance Procedure Acknowledgement

It is the policy of KidsTLC that each program will have a written grievance procedure that provides for the timely and effective resolution of complaints, disputes, and conflicts clients and their parents &/or legal guardians may experience.
KidsTLC is committed to ensuring that all consumers retain the right to file a grievance without interference or retaliation.
A description of the grievance procedure will be posted in a common area and is made available to the client and parent &/or legal guardian if applicable prior to the initiation of services. This document is read and signed during the intake process with KidsTLC Outpatient Behavioral Health Program. The signed document includes the following statement:
"I have read and fully understand KidsTLC's Outpatient Behavioral Health Grievance Procedure."
PROCEDURE:
The grievance procedure is explained during the intake process and reviewed with the client and parent &/or legal guardian if applicable as follows:
If you feel that any of your rights as a client accessing services at KidsTLC's Outpatient Behavioral Health Program have been violated, please discuss the matter immediately with your Provider (Clinician, APRN, Psychiatrist). He/she will attempt to resolve your concern(s) in a prompt and efficient manner.
If you are uncomfortable discussing the matter with your direct provider
OR

If you are not satisfied with the response that your direct provider has given you, you have the right to file a Grievance so that you may bring questions and concern(s) regarding your rights to the Vice President of Integrated Behavioral Health Solutions. He/she will fully investigate the situation and will respond directly to you within 5 business days.

Individuals receiving services at KidsTLC's Outpatient Behavioral Health Program will have full access to Grievance Forms in a private and confidential manner. Grievance forms along with complimentary envelopes are located in the main reception/waiting area of Outpatient Behavioral Health Services. These forms can be submitted in one of two ways:

1. The individual filing the grievance may hand deliver the Grievance Form to the Vice President of Integrated Behavioral Health Solutions
2. The individual filing the grievance may turn their sealed envelope containing the Grievance Form into the Receptionist who will then ensure that your confidential Grievance Form is brought to the attention of the Vice President of Integrated Behavioral Health Solutions

Whenever resolution is not possible at the Vice President of Integrated Behavioral Health Solutions level, permission will be obtained from the individual to forward the written statement of grievance to the Chief Clinical Officer and he or she will meet with the individual and/or parent(s)/legal guardian for further discussion and resolution of the issue(s).

Whenever resolution is not reached through the Chief Clinical Officer, the grievance will be forwarded to the President/CEO for review and resolution.

The grievance procedure shall be given to each client and their parent/legal guardian if applicable upon intake and shall be posted in a place accessible to clients. The grievance procedure shall be available to former clients upon request.

Whenever resolution is not reached through the Chief Clinical Officer, the grievance will be forwarded to the President/CEO for review and resolution.

The grievance procedure shall be given to each client and their parent/legal guardian if applicable upon intake and shall be posted in a place accessible to clients. The grievance procedure shall be available to former clients upon request.

KidsTLC's Outpatient Behavioral Health Program is committed to ensuring the health, safety and welfare of the children and families that are provided direct services, either in the community, client homes or agency offices. The rights and dignity of the persons served is a value to which the agency ascribes to, which is consistent with providing quality services to ensure the health, safety and welfare of the clinic's diverse clients. Therefore, as a matter of agency philosophy and service practice, the following applies to all the clinical staff, professional students/interns and volunteers within KidsTLC's Outpatient Behavioral Health Program.

Consistent with policy, KidsTLC's Outpatient Behavioral Health Program personnel will not use or practice any restrictive behavior management techniques or interventions when working with clients. This includes but is not limited to any physical holds or manual restraint, mechanical restraint, or use of isolation or locked seclusion techniques to manage a client's behavior. KidsTLC's Outpatient Behavioral Health Program staff will not teach, advocate, or otherwise support the use of such interventions with those served in the Outpatient Behavioral Health Program.

KidsTLC's Outpatient Behavioral Health Program recognizes that at times clients may become extremely upset and challenging and may become a danger to self or others. In these rare circumstances staff are expected to be consistent utilizing verbal defusing and de-escalation techniques to resolve the situation if at all possible. If a client is judged to be out of control, the staff will call for assistance as appropriate to the situation, including 911 or other emergency phone number, local law enforcement or emergency crisis team if available.

If a client reports that s/he has made a suicide attempt &/or is feeling suicidal or homicidal via telephone, s/he will be directed to dial 911 immediately. Additionally, if the client's identity and/or location are known, the On-Call personnel will also call 911 to ask for a welfare check on the consumer.

In the event that a client under the age of 18 years experiences a situation described above and requires the use of verbal de-escalation &/or police intervention, legal guardians will be contacted immediately after safety of the client has been ensured.

Group Therapy Confidentiality & Acknowledgement of Understanding

The information below outlines expectations for those participating in Group Therapy at KidsTLC Outpatient Behavioral Health Program. This information is supplied to consumers and families upon intake.

Group Therapy Confidentiality

All individuals and families involved in Group Therapy at KidsTLC Outpatient Behavioral Health Program are required to review KidsTLC's Group Therapy Confidentiality & Acknowledgement of Understanding upon intake into services and provide a signature acknowledging their understanding and agreement to abide by these policies.

The information below outlines expectations for those participating in Group Therapy at KidsTLC Outpatient Behavioral Health Program.

1. Meeting Time: The group begins and ends on time. You are expected to stay for the entire session.
2. Attendance: You are encouraged to attend group therapy if determined as part of your treatment plan on a regular basis. Vacation plans that prevent attendance at a session(s) should be brought to the group's attention prior to your vacation. If sickness occurs, please contact or leave a message for one of the group therapists before the session; otherwise you may be billed for that session. If you miss sessions and you are court ordered to attend, the courts will be notified of your missed attendance. Group sessions may be canceled for the following reasons: (a) bad weather, (b) official holidays, or (c) if the therapist is on vacation or unavailable. Every effort is made to have another practitioner cover the group if a therapist is absent for vacation or illness. If the weather conditions are uncertain or threatening, please check to see if evening classes at Johnson County Community College (JCCC) are cancelled. KidsTLC Outpatient Behavioral Health Program closes for weather when JCCC cancels for weather. If JCCC classes are held then KidsTLC Outpatient Behavioral Health Program is open.
3. Confidentiality: Strict group confidentiality must be maintained. This means that group issues, conversations, and membership identities are not to be conveyed by members to people outside of the group. There are times when the group leaders may discuss group-related information with other persons. This includes the following situations: (a) sharing information about your progress in group therapy with your individual psychotherapist, and (b) if it is believed that you are harmful or potentially harmful to yourself or someone else, appropriate people need to be informed.
4. Respect: All group members are expected to be respectful to one another and not engage in any type of verbal and/or physical aggression.
5. Termination: Reasons for termination vary and include completion of group therapy or violation of group policies. If you are leaving the group for reasons other than having to do with violation of policies, it is requested that you plan to attend at least one additional session following announcement of your intent to terminate. The purpose of this additional session is for you and the group to address issues related to your leaving.
6. Homework: On occasion, therapeutic "homework" projects may be assigned.
7. Individual Sessions: There are times when it may be necessary for you to meet individually with the group therapist. Either you or a group leader may request an individual session. Individual session(s) may be appropriate for group-related situations that do not lend themselves to group discussion. Whenever possible, issues pertaining to group will be dealt with in group. Individual sessions are billed at the individual therapy rates.
8. Breaches of Group Policy: Not abiding by these policies may lead to termination or referral.

Behavior Support Management

KidsTLC's Outpatient Behavioral Health Program is committed to ensuring the health, safety and welfare of the children and families that are provided direct services, either in the community, client homes or agency offices. The rights and dignity of the persons served is a value to which the agency ascribes to, which is consistent with providing quality services to ensure the health, safety and welfare of the clinic's diverse clients. Therefore, as a matter of agency philosophy and service practice, the following applies to all the clinical staff, professional students/interns and volunteers within KidsTLC's Outpatient Behavioral Health Program.

Consistent with policy, KidsTLC's Outpatient Behavioral Health Program personnel will not use or practice any restrictive behavior management techniques or interventions when working with clients. This includes but is not limited to any physical holds or manual restraint, mechanical restraint, or use of isolation or locked seclusion techniques to manage a client's behavior. KidsTLC's Outpatient Behavioral Health Program staff will not teach, advocate, or otherwise support the use of such interventions with those served in the Outpatient Behavioral Health Program.
KidsTLC's Outpatient Behavioral Health Program recognizes that at times clients may become extremely upset and challenging and may become a danger to self or others. In these rare circumstances staff are expected to be consistent utilizing verbal defusing and de-escalation techniques to resolve the situation if at all possible. If a client is judged to be out of control, the staff will call for assistance as appropriate to the situation, including 911 or other emergency phone number, local law enforcement or emergency crisis team if available.
If a client reports that s/he has made a suicide attempt &/or is feeling suicidal or homicidal via telephone, s/he will be directed to dial 911 immediately. Additionally, if the client's identity and/or location are known, the On-Call personnel will also call 911 to ask for a welfare check on the consumer.
In the event that a client under the age of 18 years experiences a situation described above and requires the use of verbal de-escalation &/or police intervention, legal guardians will be contacted immediately after safety of the client has been ensured.

Disability Rights Acknowledgement

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully:
Any person who becomes involved in the mental health treatment system in the State of Kansas has certain legal rights. If you feel that your rights have been violated, please contact the Disability Rights Center of Kansas, which is the designated Kansas State Department that manages your rights.

Disability Rights Center of Kansas (DRC)
635 SW Harrison Street Suite 100
Topeka, KS 66603-3726

Voice: 785-273-9661
Toll Free Voice: 1-877-776-1541
Toll Free TDD: 1-877-335-3725
Fax: 785-273-9414
A copy of this notice is to be provided to all parents and legal guardians.

KidsTLC Database

Government regulations require KidsTLC ("TLC") to collect client information. TLC utilizes a database(s), to collect information over time about the characteristics and needs of those receiving our services. TLC utilizes the information gathered to enhance services to each individual family, child, and/or youth we serve. Data is also used to evaluate the effectiveness of our services in our continuous quality improvement efforts.
All information entered into our client database is guarded with strict security policies to protect your privacy. TLC's computer system is highly secure and uses up-to-date protection features such as data encryption and passwords. As with any database there is a small risk of a security breach but the following outlines the security measures in place to minimize this risk.
Our Servers are protected by regular system wide and client specific security audits and state-of-the-art intrusion detection systems which monitor the security of the entire network from multiple access points. Protocols require operating system security upgrades and patches to be installed or updated within 24-hours of release.
All transactions are conducted over a secured connection using industry leading 128-bit Secure Socket Layer encryption, which protects confidential information from interception and hacking. . KidsTLC database software is secured using industry standard VeriSign security encryption.
All information obtained from our databases is considered confidential and is only used to support case planning and program improvements. Information will only be released to any outside entity with expressed written consent from the parent or guardian, or if over 18, the client themselves, or as otherwise required by law.
If you ever suspect the data has been misused, or have further questions or concerns please contact the System Administrator at (913) 324-3831.

E-Mail Informed Consent

KidsTLC allows the use of secure email to discuss and coordinate your care with you and with others you want us to release information to. We just want you to know a little more about what that means for you:

Email communication cannot be guaranteed to be entirely secure or confidential.
Email communication is not the best way to communicate urgent or time-sensitive information. You should use a phone call for these concerns.
Program office staff may have access to emails you send to your doctor, therapist, or worker; in the course of the work they do to support your provider.
Email may be saved electronically or printed and filed, and may become part of your medical record.
It's best to keep email concise. If your email is long or unclear, you may be called or notified to come in to discuss the matter.
You may be reminded by KidsTLC of these guidelines or changes to these guidelines from time to time.
KidsTLC reserves the right to communicate by means other than email if they think it is safer or will have a better result for you or your child.
Any liability of harm for information loss due to technical failures is waived if you choose to use email to communicate with KidsTLC.
You may tell us at any time if you don't want us to use email to communicate with *you* about you or your child's health information or treatment.

You may initiate an email to your provider using my email address at any time, but KidsTLC employees are required to use email encryption when they respond, or when they initiate email to you.
KidsTLC will:
Use email when it is deemed clinically appropriate, refraining from emailing information that should be otherwise communicated.

Only include people who need to see your information when we email.
Keep our staff emails secure and private using passwords and other security features.
Not add your email to our marketing list unless you request it.

Send only the *minimum necessary information* and only use encrypted email service if/when we send email outside of KidsTLC with your patient identifiable information.

Take all necessary precautions to prevent and avoid unauthorized access to your information if and when it is sent in email.

Please note: This consent refers to email communication between KidsTLC and your private email address ***only***. If you release information to others, or if we need to communicate with others outside of KidsTLC to collect payment, conduct operations, or provide your service, we reserve the right to use secure encrypted email to make those communications.

Consent for Evaluation and Treatment

Consent to Evaluate/Treat: I voluntarily consent that I or my child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment (aka "service"/"services") by staff from KidsTLC, Inc. Outpatient Behavioral Health Program. I understand that following the services, complete and accurate information will be provided concerning:

a. The benefits of the proposed treatment
b. Alternative treatment modes and services
c. The manner in which treatment will be administered
d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
e. Probable consequences of not receiving treatment

The services will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed.

Benefits to Evaluation/Treatment: These services may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, my minor client, or the referring professional, to understand the nature and cause of any difficulties affecting my/minor client's child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

Charges: Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

Confidentiality, Harm, and Inquiry: Information from services is contained in KidsTLC's confidential records and I consent to disclosure for use by KidsTLC, Inc staff for the purpose of continuity of care. See Client Rights for limitations of confidentiality.

□ *My protected health information (PHI) has been defined for me in the Notice of Privacy Practices, which I have read and understand. I understand the ways my PHI may be used, stored, and disclosed for treatment, operations, and payment. I also understand how I may request access to and amendment of my records and PHI.*

Right to Withdraw Consent: I have the right to withdraw my consent for services at any time by providing a written request to the treating clinician. This consent will expire 12 months from the date of signature, unless otherwise specified.

KidsTLC
Outpatient Behavioral Health
480 South Rogers Road
Olathe KS 66062
913-234-3823 phone 913-324-3890 fax

Signature Page

This is the signature page of the legal documentation provided to you, as detailed below. Please initial next to each line item indicating **t**hat you have received these documents and have had the opportunity to ask questions regarding and understand each document.

_____**Notice of Privacy Practices** I hereby acknowledge that I have received a copy of this practice's Notices of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this notice.

_____**Consumer Rights & Responsibilities Acknowledgement**. I have read and understand this policy.

_____**Grievance Procedure Acknowledgement**. I have read and fully understand the Grievance Procedure for Kids tlc Outpatient Behavioral Heath

_____**Group Therapy Confidentiality & Acknowledgement of Understanding Behavior Support Management** The policies and procedures around Kidstlc's Outpatient Behavioral Health Program regarding Behavior Support Management have been explained to me. My signature below provides consent for the above stated purposes and actions that will be taken in necessary

_____ **Behavior Support Management** The policies and procedures around Kidstlc's Outpatient Behavioral Health Program regarding Behavior Support Management have been explained to me. My signature below provides consent for the above stated purposes and actions that will be taken in necessary

_____ **Disability Rights Center of Kansas** I hereby acknowledge that I received a copy. I have been given the opportunity to ask questions about this notice.

_____ **EHR Efforts to Outcomes.** I have read and fully understand usage and confidentiality expectations as it relates to Kidstlc's Data Management System for Outpatient Behavioral Health Program.

_____ **E-Mail Informed Consent.** I read and have understood the email communication policy for Kidstlc. I allow Kidstlc to communicate with me via email pertaining to the Kidstlc email communication policy.

_____ **Consent for Evaluation & Treatment.** I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to evaluation and treatment for myself or my child (if minor client). I have read and understand my rights and responsibilities and a copy of these has been provided to me. I also attest that I am the legal guardian and have the right to consent for the treatment of this minor client (if applicable). I understand that I have the right to ask questions of the service provider about the above information at any time**.**

_____ **Financial Responsibility.**

*I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Kidstlc for any charges not covered by healthcare benefits.

*It is my responsibility to notify Kidstlc of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

*I am responsible for the entire bill or balance of the bill as determined by Kidstlc and/or my insurer if the submitted claims or any part of them are denied for payment.

* I understand that if I see a provider that is not a "eligible" provider deemed by my insurance company that I am responsible for the private pay rate. (Note some commercial insurance companies do not approve all types of therapists, if you are only covered by commercial insurance, please be sure and ask our team if your therapists is covered.)

*I understand that by signing this form that I am accepting financial responsibility as explained above for all payment of services and/or treatment provided.

_____ **Assignment of Benefits**. I authorize direct remittance of payment of all insurance benefits, including Medicaid and Medicare, to Kidstlc for all covered services provided to me during all courses of treatment and care provided. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated by Kidstlc, and will constitute a continuing authorization of any insurance policy that is in effect at the time of service, maintained on file with Kidstlc, which will authorize and allow for direct payment to Kidstlc of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, and care provided.

Client Name:

Responsible Party Signature

Responsible Party (Print Name)	Date:
Kidstlc staff:	Date:

Initial Health History – CHILD

Client Name: _____ Date of Birth: _____

PARENT/GUARDIAN INFORMATION

Name _____ Relationship to client: _____
Name _____ Relationship to client: _____
Name _____ Relationship to client: _____
Name _____ Relationship to client: _____
If divorced, which parent has custody of client_____
Has your child ever lived outside the home? No____ Yes____ If yes, please explain: _____
_____

REASON FOR EVALUATION

Please explain the reason for your child's evaluation:_____
_____
Please describe something special about your child:_____
_____
How do you explain your child's difficulties at this point? _____
_____

CHILD'S MEDICAL HISTORY

Please list any medical condition(s) for which your child is currently treated by a physician:_____
_____
Who is your child's Primary Care Doctor/Provider? _____
May we exchange information with your child's treating physicians/health practitioners to coordinate care?
Please initial: No _____ Yes _____
Medications (name, dose and reason for taking):_____
_____
Complementary and Alternative Treatments (craniosacral, acupuncture, etc.):_____
Allergies (medicine, food, environment):_____
Previous medical treatment/hospitalizations, accidents, surgeries:_____

How does your child sleep at night?_____
Described any abnormal bowel habits:_____
Does your child experience bed wetting?_____
Has your child ever had a concussion or seizure?_____
For an adolescent, please indicate the following: Age when puberty started:_____
For a girl: Age at first menstruation:_____ Date of last menstrual period:_____

PSYCHIATRIC HISTORY

Has your child ever received counseling or psychiatric treatment? No_____ Yes_____
If yes, indicate dates, name of treating professional, reason for treatment, and effectiveness of treatment:___
_____
Has your child ever had a psychiatric hospital stay or a PRTF placement? No_____ Yes_____
If yes, indicate dates, name of hospital/PRTF, reason for stay: _____
_____
Has your child ever had any of the following evaluations?
Psychiatric or neurology evaluation: No__ Yes___ If yes, name of evaluator: _____
Date/reason for evaluation: _____
Psychological/neuropsychological testing: No__ Yes___ If yes, name of evaluator: _____
Date/reason for evaluation: _____
School testing: No__ Yes___ If yes, name of evaluator: _____
Date/reason for evaluation: _____

SOCIAL HISTORY

Who lives in the home?_____
Describe any stress the family is experiencing:_____
What causes your child stress?_____
Who in the family is the child closest to?_____
Anyone in the family who the child frequently has conflict with:_____
List siblings who live outside the home:_____
How does your child relate to other children?_____
Does your child prefer to play with younger or older children?_____
Does your child have a best friend? No _____ Yes _____
How many friends does your child have?_____

What are your child's favorite activities?_____
Have your child's interests in these activities changed recently? No _____ Yes _____
What activities does your child like least?_____

Does your child use alcohol? No_____ Yes_____ Does your child use street drugs? No____ Yes____
If yes, explain: _____
Has your child been in trouble with the law? No_____ Yes_____
If yes, describe briefly: _____
Has your child experienced traumatic events?
If yes, describe briefly: _____

DEVELOPMENTAL HISTORY

Length of pregnancy: _____ weeks
Were any of the following used during pregnancy?
Cigarettes____ Alcohol____ Non-prescription drugs____ Unknown____
Please list any medications taken during pregnancy? _____
Please list any complications during pregnancy/labor/delivery: _____
Birth weight: _____lbs _____ oz

Early Development (during 1st year)

Describe any sleeping problems:_____
Describe any feeding problems:_____
As an infant, was the child abnormally quiet? No _____ Yes ____
Would you have described the child as fussy? No _____ Yes ____
As an infant, did the child like to be cuddled? No _____ Yes ____
When upset, was the child able to be comforted? No _____ Yes ____

Early Behavior/Temperament (Birth to 5 years)

Describe any concerns or problems in the child's growth or development in the first few years:_____
_____
Has a developmental assessment been done? No _____ Yes _____
If so, please explain:_____

The following is a list of infant and preschool behaviors. Please indicate if your child reached these milestones within approximate average age range. Please explain below any problems with these milestones being reached.

Behavior	Within Normal Limits	Behavior	Within Normal Limits
Showed response to mother	Y/N _____	Walked alone	Y/N _____
Rolled over	Y/N _____	Put several words together	Y/N _____
Sat alone	Y/N _____	Became toilet trained	Y/N _____
Crawled	Y/N _____	Stayed dry all night	Y/N _____
Spoke first word	Y/N _____	Rode tricycle	Y/N _____

Explain:_____

EDUCATIONAL HISTORY

Grade: _____ School: _____ Contact: _____

Place a check next to any educational problems that your child currently exhibits:

____ Difficulty with reading ____ Difficulty with writing

____ Difficulty with math ____ Does not like school

____ Has difficulty with other subjects (please list):_____

Does your child have an IEP? No ____ Yes ____ If yes, is it for learning or behaviors or both?_____

Is your child in a special education class? No ____ Yes____ If yes, in which grade was placement made? _____

What type of class?_____ How much time each day?_____

Describe any handicapping conditions:_____

Has your child been held back in a grade: No _____ Yes _____

If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school? No _____ Yes _____

If yes, please describe: _____

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of the immediate family has had. When you check an item, please note the family member's relationship to the child.

	Condition	Relation to Child		Condition	Relation to Child
____	Cancer	_____	____	Schizophrenia	_____
____	Diabetes	_____	____	Suicide attempt	_____
____	Heart Trouble	_____	____	ADD/ADHD	_____
____	Bipolar Disorder (manic depression)	_____	____	Disruptive Mood Dysreg. Disorder	_____
____	Alcoholism	_____	____	Autistic Spectrum	_____
____	Drug Abuse	_____		Other (specify)	
____	Depression	_____	____	_____	_____
____	Anxiety	_____	____	_____	_____

Comments:_____

BEHAVIORAL SYMPTOMS

Does your child have difficulty with any of the following problems? If yes, please explain.

No__ Yes__	Trouble meeting new people; is shy or withdrawn	_____
No__ Yes__	Overly anxious	_____
No__ Yes__	Fears/phobias	_____
No__ Yes__	Sad or depressed	_____
No__ Yes__	Thoughts of suicide	_____
No__ Yes__	Refuses to comply with adults requests/violates rules	_____
No__ Yes__	Physically cruel to people or animals	_____
No__ Yes__	Inattentive/poor focus	_____
No__ Yes__	Restless/fidgety	_____
No__ Yes__	Trouble playing quietly	_____
No__ Yes__	Frequent mood shifts	_____
No__ Yes__	Frustrates easily	_____
No__ Yes__	Eating problems (picky, etc.)	_____
No__ Yes__	Hallucinations	_____

Comments:_____

REVIEW OF SYSTEMS

Please check the boxes below to indicate if your child is having any of the following symptoms. If they had the symptom in the past, but not now, please circle the "yes" box.

Constitutional	No	Yes	Eyes	No	Yes	Ears/Nose/ Throat	No	Yes	Respiratory	No	Yes
Weight Loss	☐	☐	Blurry Vision	☐	☐	Sore Throat	☐	☐	Short of Breath	☐	☐
Fevers	☐	☐	Eye Pain	☐	☐	Tinnitus	☐	☐	Cough	☐	☐
Chills	☐	☐	Discharge	☐	☐	Bloody Nose	☐	☐	Coughing Up Blood	☐	☐
Night Sweats	☐	☐	Dry Eyes	☐	☐	Hearing Loss	☐	☐	Wheezing	☐	☐
Fatigue	☐	☐	Double Vision	☐	☐	Sinusitis	☐	☐	Painful Breathing	☐	☐
Gastrointestinal	**No**	**Yes**	**Genitourinary**	**No**	**Yes**	**Musculoskeletal**	**No**	**Yes**	**Skin**	**No**	**Yes**
Nausea	☐	☐	Blood In The Urine	☐	☐	Joint Pain	☐	☐	Rash	☐	☐
Vomiting	☐	☐	Painful Urination	☐	☐	Muscle Pain	☐	☐	Itching	☐	☐
Diarrhea	☐	☐	Incontinence	☐	☐	Muscle Weakness	☐	☐	Sores	☐	☐
Belly Pain	☐	☐	UTIs	☐	☐	Joint Swelling	☐	☐	Nail Changes	☐	☐
Constipation	☐	☐				NSAID Use	☐	☐	Skin Thickening	☐	☐
Neurological	**No**	**Yes**	**Endocrine**	**No**	**Yes**	**Hem/Lymphatic**	**No**	**Yes**	**Allergic/Immune**	**No**	**Yes**
Frequent Headaches	☐	☐	Excess Thirst	☐	☐	Easy Bruising	☐	☐	Allergic Rhinitis	☐	☐
Numbness	☐	☐	Frequent Urination	☐	☐	Easy Bleeding	☐	☐	Hay Fever	☐	☐
Dizziness	☐	☐	Cold Intolerance	☐	☐	Blood Clots	☐	☐	Asthma	☐	☐
Tremors	☐	☐	Heat Intolerance	☐	☐	Swollen Glands	☐	☐	Positive PPD	☐	☐
Vertigo	☐	☐	Goiter	☐	☐	Lymphedema	☐	☐	Hives	☐	☐
Cardiovascular	**No**	**Yes**	**Psychiatric**	**No**	**Yes**	**Comments:**					
Chest Pain	☐	☐	Mania (too happy)	☐	☐						
Trouble Breathing Laying Down	☐	☐	Racing thoughts	☐	☐						
Palpitations	☐	☐	Irritability/anger	☐	☐						
Edema	☐	☐	Nightmares	☐	☐						
Fainting	☐	☐	Obsessions	☐	☐						

PARENTING AND DISCIPLINE

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use and mark if it was helpful.

	Used	Helpful		Used	Helpful
Ignore problem behavior	_____	_____	Tell child to sit on chair	_____	_____
Scold child	_____	_____	Send child to his/her room	_____	_____
Spank child	_____	_____	Take away activity or food	_____	_____
Threaten child	_____	_____	Other techniques (describe)	_____	
Reason with child	_____	_____	_____		
Redirect child's interest	_____	_____	_____		
No particular technique	_____	_____	_____		

Your level of stress as a parent: Low__ Mod__ High__ Describe:_____
Are you still able to enjoy your child? Yes__ Some__ No__ Describe:_____

Is there any other information that you think may help us in working with your child?_____
_____
_____

_____
Client signature/Date

_____ _____
Signature of parent or guardian/Date Reviewed by/Date

Outpatient Behavioral Health Program
620 South Rogers Road
Olathe, Kansas 66062
913.324.3823

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client's Full Name	*Maiden Name* (if applicable)	*Social Security Number*	*Birthdate*

I hear by authorize KidsTLC Outpatient Behavioral Health to:

- ❑ **Release to**
- ❑ **Obtain Information From**

Name of Agency and/or Individual | *Phone Number*

At *Full Address – Street number, Street, City, State, Zip Code* | *Fax Number*

Information to be released: (PLEASE INITIAL EACH ITEM APPROVED)

___ All information necessary to provide services
___ Academic, achievement or aptitude evaluations and recommendations
___ Social, behavioral, psychological, or mental evaluations
___ Medical histories or Tests/Lab results
___ Diagnostic and treatment progress and prognoses
___ Alcohol & Drug Histories and Evaluations
___ Results of previous treatment
___ Other (specify)

The purpose of this release is to share information regarding treatment. The information will be used to develop and coordinate individual treatment plans.

READ BEFORE SIGNING:

I understand that the information which I have authorized to be disclosed will be used for the purpose(s) stated. I acknowledge that it is my responsibility to be aware of any rights of confidentiality and that my records are protected by law and cannot be disclosed without my consent. I further understand that by signing this form I am giving consent and waiving my right, if any, to confidentiality for the purpose(s) I have approved. This Authorization will automatically expire 1 year after the date entered below (date of signature) or by revoking it any time prior. Any information released prior to revoking will be processed legally and with consent.

Client Signature (if 18 or over)	*Printed Name of Client*	*Date*
Parent/Legal Guardian Signature	*Printed Name of Parent/Legal Guardian*	*Date*