College Park Youth & Family Services

Welcome-

I would like to thank you for choosing College Park Youth & Family Services. We are here to serve you and your family.

Our purpose is to work with you and your family to address problem areas and identify solutions. We believe that therapy is a joint effort and have designed our policies with that in mind. We have found that counseling works best on a weekly basis and so we ask for you to attend consistently. Your attendance at the appointed therapy times is critical to our being able to work together.

We have enclosed several forms in this packet. We ask that you review, sign, and return them. You have the right not to sign any form.

It is often helpful for your therapist(s) to confer with other agencies such as schools, physicians, or previous therapists in order to have a clearer understanding of your family. To do this, we must have your written permission.

Also, there may be an occasion in the future, when we may contact you to ask you to share your experience with our program with those who fund this program or elected officials. These individuals often find it helpful to hear directly from those who have used our services. Of course, you will never be obligated to participate.

We encourage any suggestions and/or questions you may have about our services and welcome you as a client.

Sincerely,

Peggy Higgins

Peggy Higgins, LCSW-C
Director

09/07

4912 Nantucket Road ♦ College Park, MD 20740-1458 ♦ 301 • 474-1210 ♦ 301 • 474-0717 FAX

FOR EACH OF THE FOLLOWING QUESTIONS PLEASE INDICATE YOUR SATISFACTION.

1= Extremely dissatisfied
2= Very dissatisfied
3= Somewhat dissatisfied
4= Mixed
5= Somewhat satisfied
6= Very satisfied
7= Extremely satisfied

___ 1. How satisfied are you with the behavior of your children?
___ 2. How satisfied are you with yourself as a parent?
___ 3. How satisfied are you with your relationship with your children?

YOUR CONCERNS FOR YOUR CHILD AND FAMILY:

- What brings you here? _____
  _____
- When did you first notice this? _____
  _____
- What have you tried that has helped the problem? _____
  _____
- What have you tried that hasn't helped the problem? _____
  _____

09/07

STATEMENT OF CONFIDENTIALITY OF CLIENT RECORDS

College Park Youth & Family Services adheres to all laws regarding the confidentiality of client information. The confidentiality of clients' records is protected by State and Federal law regulations. No information regarding the treatment of any College Park Youth & Family Services' client shall be disclosed to any non-bureau person of a monitoring agency without the express written consent of the client. Even with a written release, disclosure of client information by the College Park Youth & Family Services shall be limited to the minimum of identifiable information necessary for the intended purpose of its release.

However, under the following circumstances, client authorizations are not required.

1. Disclosures required by law (subpoena).
2. Medical and/or psychiatric emergencies.
3. Suspected child abuse and neglect.
4. Threats to physically harm self or another person.

Law and regulations require the reporting of suspected child abuse or neglect to appropriate state and local authorities.

Law and regulations require that threats to physically injure another person be reported to that person.

I, _____, have read and understand my and my family's rights.

_____ _____

Youth Date Therapist Date

_____

Parent/Guardian Date

10/10

PERMISSION TO RENDER SERVICES

I,_____, hereby give permission for

_____ to receive counseling from the College Park Youth and Family Services.

_____ _____

Date Parent/Guardian

_____

Therapist

09/07

COLLEGE PARK YOUTH & FAMILY SERVICES

INFORMED CONSENT

In order to comply with research, evaluation and funding requirements, College Park Youth and Family Services provides the following information to the Department of Juvenile Services.

a) Youth's full name
b) Youth's date of birth

Two years after termination, our list of terminated clients is checked by the Department of Juvenile Services staff against their list of youth involved in the Juvenile Justice system. The purpose of this procedure is to aid them in evaluating our program.

The information reviewed is the name, birth date, and the beginning and ending dates of service of the juveniles served. Information about counseling sessions and counseling content is not released. The names of those youth who are not known to the Department of Juvenile Justice will be reviewed, but will not be retained by the Department.

I have read the information stated above relating to the release of limited information to the Department of Juvenile Services by College Park Youth & Family Services and hereby give the College Park Youth and Family Services my permission to do so. I understand that if my child is not known to the Department, the Department reviews the information but does not retain any of the documentation.

Youth's Name: _____
(First) (Middle) (Last)

Parent/Guardian: _____ Date: _____

Witness/Therapist: _____ Date: _____

7/12

HIPAA
Health Insurance Portability and Accountability Act

Notice of Privacy Practices

We care about our client's privacy and strive to protect the confidentiality of your health information. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your health information, and College Park Youth And Family Services is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the privacy officer, Peggy Higgins, LCSW-C.

If you would like detailed information regarding how we use and disclose information about you and your individual rights, please let us know and you will be provided with a copy of our Notice of Privacy Practices.

I am aware that College Park Youth And Family Services, as required by law, maintains the privacy of protected health information as prescribed by HIPAA and that I have access to its provisions. I have been provided an opportunity to review the Notice of Privacy Practices. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in the notice. I may revoke this authorization at any time in writing.

_____ _____

Print Name Date of Birth

_____ _____

Signature Date

09/07

COLLEGE PARK YOUTH & FAMILY SERVICES

INFORMED CONSENT

I, _____, the parent, and/or guardian of _____, residing at_____ do hereby give permission for College Park Youth & Family Services to audiotape/videotape or to observe behind the one-way mirror, counseling sessions of my family, including myself, for the purpose of supervision of our/my therapy. I retain the right to revoke this permission at any time or for any individual session. I/We understand that these tapes will be held confidential and kept in a locked file.

_____ _____
Date Parent and/or Guardian

_____ _____
Date Parent and/or Guardian

_____ _____
Date Therapist

09/07

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COLLEGE PARK YOUTH & FAMILY SERVICES

CLIENT RIGHTS AND RESPONSIBILITIES

We believe that a respectful relationship serves the client's well-being and the professional standards of the therapist.

You have the right as a client:

1. To be treated with dignity and respect.
2. To the most appropriate treatment available regardless of sex, age, race, color, religion, national origin, disability or other status applicable under Federal laws.
3. To privacy concerning your conversation and treatment records.
4. To actively participate in setting your treatment plan.
5. To obtain information regarding your treatment plan.
6. To be met on time for appointments or, if need be, notified of any changes as early as possible.
7. To be informed of the agency policy for missed appointments.

You have the responsibility as a client:

1. To keep your scheduled appointment time and to be on time for your session. Therapy sessions are 50 minutes in length.
2. To notify the agency as soon as possible regarding the need to change your appointment schedule. This should be done at least a day in advance of your scheduled appointment.
3. To share in the planning of counseling goals and cooperate to achieve the best treatment for you and your family.
4. To let us know if you are satisfied or dissatisfied with services.

We encourage any feedback, suggestions and/or questions you may have about you services and we welcome you as a client.

Sincerely,

Peggy Higgins, LCSW-C
Director

_____ _____

Parent/Guardian Therapist

_____ _____

Date Date

9/07

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