Purposeful Parenting , LLC

Consent to Treatment

The general terms of service have been explained to me and I agree to them as a client/family receiving treatment from Purposeful Parenting LLC.

I understand that even though services may be court ordered, I may terminate services with Purposeful Parenting LLC at anytime. I may terminate services by contacting my service provider via either email or phone or by contacting my DCS Case Manager, Juvenile Probation Officer, or Choices Care Coordinator.

You have the right to discontinue your work with Purposeful Parenting LLC at any time. We would ask that you give us the opportunity to discuss this so as to obtain appropriate closure. If you choose to continue your work with another professional and do not have referrals, we will provide you with the names of other qualified professionals whose services you might prefer. We can also be available for consultation with your new provider in an effort to help provide you with continuity of your care if so desired. Your only obligation at the point of termination is that of a financial nature for services already rendered and not yet paid in full. Arrangements can be made upon request.

Cancelling services may alter judicial/court standing; please contact your DCS Case Manager, Juvenile Probation Officer, or Choices Care Coordinator if you have additional comments, questions, or concerns.

Cancellation Policy

Your appointment time is reserved specifically for you. Please try to be on time for all sessions. If the session is held in our office and you are late, we will meet for the time remaining in the session. If the session is held in your home and you are late the provider will wait 10 minutes, if you arrive we will meet for the time remaining in the session.
In the event you must cancel a session, a minimum of 24-hours' notice is required. If you miss three appointments or are out of communication for two weeks, without notifying your provider your case may be: (1) closed; (2) placed on an attendance contract; (3) or staffed at an upcoming CFTM for additional intervention. ***It is your responsibility to immediately contact your provider if your phone or address status changes.***

Emergency Procedures

For life threatening emergencies, call 911. If you need to contact our office between sessions for routine/non-emergency matter, you may call the office at (317) 455.5307 or your assigned provider directly at the number they have provided to you. Messages left at the office will be responded to within the same 24-hour period during the business week. Calls left after 5 p.m. on Fridays will be returned at the beginning of the next week.

PLEASE CONSULT YOUR SAFETY PLAN FOR ADDITIONAL EMERGENCY PROCEDURES

It is important to understand that Purposeful Parenting LLC is not an emergency or crisis clinic, and there may be a time when we are not readily available, particularly during working hours when seeing other clients.

Please call 911 in the event of an emergency

Statement of Confidentiality

Professional ethics and Indiana State Law specify that communications between a client and the therapist are privileged and confidential. Confidential information may not be released or shared without the written permission of the client. There are, however, some exceptions to the rule where disclosure is required by law. Disclosure may be required in the following circumstances:

1. You reveal information about ***child abuse/neglect or elder abuse,*** we are required by law to report this to the appropriate authority. Any reasonable suspicion of these matters may also be reportable.

2. If you indicate that you have a ***plan, the means, and make credible threats to kill yourself,*** we are required by law to notify potential helpers, which may include law enforcement agencies, in order to provide you with a safe place where no harm can come to you. This can be done voluntarily which is ideal or if the threat is serious and of concern, an involuntary action may be taken.

3. If you tell your provider that you have a ***plan, the means, and make credible threats to harm someone else,*** we are required by law to notify/warn potential helpers, appropriate law enforcement agencies, and in those cases where identifiable others may be harmed, notification of potential victim(s) will be made as mandated under the law.

4. If you are in therapy or being tested by order of a court of law (judge's order) the results of the treatment or tests ordered must be revealed to that court (this includes the Department of Children Services).

5. If a court of law issues a legitimate subpoena, we are required by law to provide the information specifically described in the subpoena.

6. Disclosure of confidential information may be required by the Indiana Department of Child Services, Medicaid, and/or Choices, Inc. in order to process claims. If you so instruct, only the minimum necessary information will be communicated to the biller. We have no control or knowledge over what these agencies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain future insurance.

Please ask questions you may have about any of the procedures mentioned above or any you may have throughout the course of your work with Purposeful Parenting LLC.

We do keep written records of all sessions. You have the right to receive a summary of your records. Your provider may need to be present when you review the summary of your records. If you ask Purposeful Parenting LLC to release information to other agencies or person(s), you will have to sign a written release of information form. You will be informed at the time of your request whether or not it is our professional opinion that releasing that information to that agency or person(s) might be harmful to you in any way. If a third party makes a request for your records, we will always offer a summary of your record of treatment.

_____ _____

Print Client Name Signature of Client and Date

_____ _____

Print Parent/Guardian Name Signature of Parent/Guardian and Date

_____ _____

Provider Name Signature of Provider and Date

Purposeful Parenting LLC

Client Bill of Rights and Responsibilities

The purpose of this policy is to inform you, as the client, of your rights and responsibilities while working with Purposeful Parenting LLC service provider. In order to provide the best service we can offer, it is important to have your participation. If you have any questions or concerns about your rights and responsibilities as the client, please speak with your provider. Contacts for reporting are listed below.

Your rights as a client of Purposeful Parenting, LLC include:

1. The right to professional and appropriate treatment.
2. The right to know the qualifications of the provider you are working with.
3. The right to be informed of any cancellation, rescheduling, transfer, or discharge in a reasonable amount of time.
4. The right to request information regarding your case, including any diagnosis, treatment plans, and goals.
5. The right to receive said information in a timely manner.
6. The right to be involved in the construction of treatment plans.
7. The right to receive services free of discrimination on the basis of race, religion, gender, or other legally protected category.
8. The right to be free from neglect, exploitation, and any form of abuse (verbal, mental, physical, and sexual).
9. The right to services that support dignity and positive self-regard.
10. The right to report any ethical or safety concerns to Purposeful Parenting LLC.

Your responsibilities to Purposeful Parenting, LLC include:

1. The responsibility to inform your provider of any changes to scheduling, needs, etc.
2. The responsibility to be an active and engaged participant in services.
3. The responsibility to ask questions to ensure understanding of any and all information or services provided.

I have received a copy of Purposeful Parenting, LLC *Client Bill of Rights and Responsibilities*.

☐ Yes ☐ No

I understand my rights and responsibilities outlined in this document.

Client Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Provider Signature_____ Date_____

<u>Contacts for Reporting</u>

Purposeful Parenting LLC 317-317-455-5307

Department of Child Services 317-968-4300

Indiana Child Abuse/Neglect Hotline 1-800-800-555

Purposeful Parenting , LLC

HIPPA & Client / Family Privacy Policy

Notice of Policies and Practices of Purposeful Parenting, LLC to protect the Privacy of Your Health Information

I give my consent for service provider associated with *Purposeful Parenting, LLC* to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and other designated agencies identified responsible for payment and for health care operations like quality review.

I understand that a service provider from *Purposeful Parenting, LLC* may use or disclose health information without my consent or authorization in the following circumstances:

- Child Abuse & Neglect: If I have reasonable cause to believe that a child has been abused and/or neglected, I must report that belief, as required by law, to the appropriate authorities.

- Adult, Domestic, or Animal Abuse: If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief, as required by law, to the appropriate authorities. In addition, if I have reasonable cause to believe that an animal or pet has had a physical injury or injuries inflicted upon them, other than by accidental means, or has been neglected or exploited, I must report this belief to the appropriate authorities.

- Health Oversight Activities: If a governmental agency, such as the Indiana Attorney General's Office or the Indiana Department of Children Services / Child Protective Services, is conducting an investigation and/or audit into my practice, then I am required to disclose PHI upon receipt of a subpoena or appropriate request.

- Judicial and Administrative Proceedings: If the client is involved in a court proceeding and a request is made for information about the professional services I provided you and/or the record thereof, such information is privileged under state law, and I will not release information without the written authorization of you (or your legally appointed representative) or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- Serious Threat to Health or Safety: If I determine, or pursuant to the standards of my profession should determine, that you present a clear and immediate probability of physical harm to yourself, to other individual(s), to society, public/private property, or an animal/pet I may communicate relevant information concerning this to the potential victim, appropriate family member, medical or law enforcement personnel, or other appropriate authorities.

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HIPPA & Client / Family Privacy Policy

- Worker's Compensation: If you file a worker's compensation claim, I may be required to disclose PHI, such as your diagnosis and treatment records, to relevant parties or officials. I may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law that provide benefits for work-related injuries or illness without regard to fault.

- In addition to the aforementioned reasons, Purposeful Parenting, LLC may also share Health Information with the following representatives and entities:

  ☐ *Choices, Inc.* Care Coordinator: _____
  ☐ Juvenile Probation Department: _____
  ☐ Indiana Department of Children Services Representatives: _____
  ☐ County Court and Representatives: _____
  ☐ HSPP, MD: _____
  ☐ Other: _____
  ☐ Other: _____

I have been informed that I may review *Purposeful Parenting, LLC* notice of privacy practices before signing this consent.

I understand that *Purposeful Parenting LLC, LLC* has the right to change their privacy practices and that I may obtain any revised notices at *Purposeful Parenting, LLC*
I understand that I have the right to request a restriction of how my protective health information is used. However, I also understand that Purposeful Parenting, LLC is not required to agree to the request. If *Purposeful Parenting, LLC* agrees to my requested restriction they must follow the requested restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already requested or disclosed.

_____	_____
Print Client Name	Signature of Client and Date
_____	_____
Print Parent/Guardian Name	Signature of Parent/Guardian and Date
_____	_____
Provider Name	Signature of Provider and Date

Purposeful Parenting , LLC

Confidential Information Consent

I,_____, do hereby consent and authorize ***Purposeful Parenting LLC, LLC.*** as indicated below to obtain from and release to:

_____ Name of person / Title / Organization

_____ Relationship to Client

_____ Address / City / State / Zip

_____ Phone Number

The following information pertaining to: _____ Client Name

_____ Client's Date of Birth

_____ Expiration Date

THE INFORMATION WHICH MAY BE DISCLOSED IS:

OBTAIN	RELEASE		OBTAIN	RELEASE	
☐	☐	Presence in treatment (admit/discharge dates)	☐	☐	Bio-psychosocial/diagnostic summary
☐	☐	Medical history and physical examination	☐	☐	Health records
☐	☐	Discharge Summery/Continuing care plan	☐	☐	Educational testing records
☐	☐	Educational records/achievements/assessments	☐	☐	Immunization records
☐	☐	Psychological tests/protective assessments	☐	☐	Medical discharge summary

Other: _____

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSES:

☐ To provide ongoing treatment / continuing care
☐ To provide educational services
☐ Coordinate services with authorized school officials
☐ To coordinate educational planning and re-entry program with school persons
☐ To enable judges, attorney, probation / parole officers to support treatment goals or make legal decisions on my behalf
☐ Other: _____

I UNDERSTAND THAT I NEED TO CONSENT TO RELEASE OF INFORMATION IN ORDER TO OBTAIN SERVICES. I CHOOSE TO DO SO WILLINGLY AND VOLUNTARY FOR THE PURPOSE SPECIFIED ABOVE. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME BY NOTIFYING THE ADMINTRATOR IN WRITING, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON MY CONSENT. SIGNING OR NOT SIGNING THIS CONSENT WILL NOT AFFECT THE QUALITIY OR QUANTITY OF SERVICES.

_____ Client Name

_____ Signature of Client and Date

_____ Parent/Guardian Name

_____ Signature of Parent/Guardian and Date

_____ Signature Provide Name

_____ Signature of Provider and Date

NOTICE TO RECIPIENT OF INFORMATION: Information has been disclosed to you from records whose confidentiality is protected by Federal or Indiana laws and regulations. Such laws prohibit you from making any further disclosure of the information without specific written consent of the person to whom the information pertains or as otherwise permitted by such laws and regulations. A general authorization for release of medical or other information is not sufficient for this purpose. The Federal and Indiana laws and regulations restrict any use of the information to criminally investigate or prosecute any patient.

Remote Services Informed Consent Form

(For clients who wish to engage in remote services)

Remote Services Option & Client Privacy: I, the client, understand that Purposeful Parenting LLC currently offers remote services. Collaborative I fully understand that this format does not guarantee client confidentiality and is not HIPPA protected.

Technology Failure: I, the client, do understand that in the event of a technology failure during a session that immediate steps will be taken by the provider to reconnect. If re-connection persists the provider will reach out to schedule another session at a later date for the remaining time of the session that was not used.

Recording of Sessions: I understand that Purposeful ParentingLLC will not record my sessions unless there is an explicit written consent by me for reasons that clearly benefit my services.

I understand that in the event of an emotional crisis and I cannot reach Purposeful Parenting LLC, I can follow this Emergency Plan:

*Call 911 or local emergency response team
*Go to the nearest emergency room

I have had ample opportunity to ask questions and receive clarification about this option and this policy. I understand that remote sessions will be held remotely or in person in accordance with state standards of face to face contact have opted to participate in remote sessions at this time. I understand that I have the option to change my mind at any point in time and I will do so in writing. I do recognize the potential risk of compromise to my confidentiality by participating in remote sessions. I wish to proceed knowing these risks.

_____

Client Name

_____

Signature Date

Purposeful Parenting, LLC

Adult Safety Plan

Client Name:_____ **Date: _____**

This agreement is to be generated in a clinical context; the therapist, juvenile, family member(s)/caregivers, supervising agent should all have input. This document does not have any explicit or implicit authority, and does not replace, supersede, or do anything other than inform the court of agreements made by the attendant parties. It may develop into a plan for the ongoing supervision of the juvenile, but it must be revised and adjusted with the involvement of a multi-disciplinary team, (MDT). It is not exhaustive, and should have additions and specifications designed for the particular family/juvenile's circumstances or situations.

PURPOSE OF AGREEMENT:

1. Promote safety in the home – prevent self-harm.
2. Promote safety for any vulnerable person – emotional, physical and sexual.
3. Promote comprehensive awareness of characteristics and risk factors.
4. Reduce/eliminate opportunities for further unhealthy behaviors.

Safety Plan Objectives:

1. Client will adhere to all **DCS court orders**.
2. Client will not allow any **fighting or relationship violence** to occur while in the presence of children.
3. Client will **keep children safe from sexual abuse** by complying with DCS safety plan.
4. Client will **utilize age appropriate discipline and no physical discipline** or punishment will be used as part of the safety plan.
5. Client will make sure that all **firearms and weapons are stored safely** and securely away from all children.
6. Client will **provide safe housing and all basic daily needs** for children in the household.
7. Client will adhere **to no-contact orders** in place (if applicable).
8. Client will schedule and **attend appointments** (therapy, case management, school, medical, etc.)
9. Client will comply with any **medication management** that may be needed.
10. Client will avoid all **substance or alcohol use**.
11. Client will submit to **drug screening** as instructed.
12. Client will report any **thoughts of harming self or others** to_____
13. Client: _____
14. Client: _____
15. Client: _____

_____ _____

Print Client Name Signature of Client and Date

_____ _____

Provider Name _ Signature of Provider and Date