Ms. Katherine M. Curran, Esq.
President & Chief Executive Officer

Dr. Jennifer Cohen, M.D.
Chief Medical Officer

Greetings Parent/Guardian:

As a student at **Henry Abbott Technical High School**, your child is eligible to receive medical and mental health services offered during school hours through an on-site CIFC Health **School Based Health Center (SBHC)**.

CIFC Health SBHC is *different* from the school nurse office and school guidance/social work office, as it is staffed by an outside, non-profit entity, CIFC Health. CIFC Health is a federally qualified health center with headquarters in Danbury and has SBHCs throughout the region.

Our medical and behavioral health providers can assess your child's medical and behavioral health conditions much like pediatric doctor and/or private behavioral health provider practices. We can also diagnosis and treat medical issues like an urgent care facility or minute clinic does, offering same-day appointment on site, without having parent/guardian leave work to take child for care off site.

On-site medical services include:

Complete physical exams, vaccines, diagnose and treat common illnesses such as ear infections, headaches, pneumonia, rashes, strep throat, allergies, health education for nutrition, exercise, weight, asthma education, and inhaler refills. Providers can send prescriptions for medications directly to your pharmacy.

Mental health services include:

Assessment for individual, group, and/or parent family therapy, assistance with peer/family relationships, anxiety/depression, behavior problems, exposure to trauma/loss, poor academic performance/learning challenges, history of or current self-harm and suicidal ideation, and transition to new home/school location.

****

To use the above services, parent/guardian must complete, sign, and return to the SBHC, the attached registration packet, and attach a current copy of the front and back side of your child's insurance card.
All information must be filled out on the forms with signatures, or it will be returned to you.

Insurances will be billed for all eligible medical or mental health visits, and invoices for co-pays and/or deductibles will be sent home following scheduled visits.

If your child is not currently covered by a health insurance plan, assistance is available. Please contact **CIFC Financial & Insurance Assistance** for help enrolling in the **Connecticut HUSKY Health Insurance Program** or to determine eligibility for a sliding-fee scale payment plan. You may also apply directly to the Connecticut HUSKY program using the contact information below.

- **CIFC Financial & Insurance Assistance: 203-448-2668**
- **Connecticut HUSKY Health Insurance: 1-855-805-4325**
- **Henry Abbott Technical High School - School Based Health Center: 203-797-4460 EXT. 12111**
- **Henry Abbott Technical High School - School Based Health Center: Fax: 203-797-2788**

On behalf of the staff at Henry Abbott Technical High School CIFC Health SBHC, we look forward to assisting your child to be healthy, happy, and ready to learn!

CIFC Health

Patient Information

Last Name:	First Name:	M.I.	Date of Birth (mm/dd/yyyy):

Street Address:	Apt/Floor:	City:	State:	Zip Code:

Primary Pharmacy (including address):	Primary Care Provider (PCP):	Dentist:

Parent Information

	Last Name:	First Name:	Date of Birth (mm/dd/yyyy):	Phone:
Mom				

Street Address: ☐ Address same as patient (if checked, skip to next section)	Apt/Floor:	City:	State:	Zip Code:

	Last Name:	First Name:	Date of Birth (mm/dd/yyyy):	Phone:
Dad				

Street Address: ☐ Address same as patient (if checked, skip to next section)	Apt/Floor:	City:	State:	Zip Code:

Insurance

Do you have Health Insurance? ☐ YES ☐ NO	If NO, would you like to see if you qualify for? ☐ Health Insurance – Access Health CT ☐ Financial Assistance (sliding-fee scale)

PRIMARY	Company Name:	ID #:	Group #:

Last Name:	First Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:

SECONDARY	Company Name:	ID #:	Group #:

Last Name:	First Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:

Person Responsible for Payment

Person Responsible for Payment: ☐ **Mom (if checked, skip to next section)** ☐ **Dad (if checked, skip to next section)** ☐ **Other:** _____

Last Name:	First Name:	Date of Birth (mm/dd/yyyy):	Phone:

Street Address: ☐ Address same as patient (if checked, skip to next section)	Apt/Floor:	City:	State:	Zip Code:

Income — CIFC Health receives Federal Grants which require us to ask for this information.

# of People in Household:	Household Income:	☐ Annually ☐ Monthly: How many months/year? _____ ☐ Weekly: How many weeks/year? _____
_____	$_____	

Required Information (For Patient)

Are you Homeless?
☐ **YES** *(Select below)* ☐ **NO** *(Skip below)*
- ☐ Doubling-up *(living with another family)*
- ☐ Street
- ☐ Homeless Shelter *(temporary/overnight stay)*
- ☐ Transitional *(longer temporary housing)*
- ☐ Other: _____

Sex Assigned at Birth:
- ☐ Male
- ☐ Female

Employment Status:
- ☐ Retired
- ☐ Employed – Full-time
- ☐ Employed – Part-time
- ☐ Self-Employed
- ☐ Unemployed
- ☐ Student – Full-time
- ☐ Student – Part-time
- ☐ N/A (Child)

Language Preference:
- ☐ English
- ☐ Spanish
- ☐ Portuguese
- ☐ Other: _____

Need Translator?
- ☐ YES
- ☐ NO

Ethnicity:
Hispanic/Latino
- ☐ Yes

Which country:

_____
- ☐ Not Hispanic/Latino
- ☐ Decline to answer

Race:
- ☐ White
- ☐ Black/African American
- ☐ Asian:

Which country:

_____
- ☐ Native American/Alaskan
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Decline to answer

Signature of Patient/Guardian:	**Date:**

School Based Health Center (SBHC)
Permission and Medical History Form

Student's Name: _____ **Date of Birth:** _____

1) Is the student under the care of any medical specialist? ☐ Yes ☐ No If Yes Which specialist. _____
2) Has student seen a dentist within the last year? ☐ Yes ☐ No
3) Has student seen the same dentist for more than one year? ☐ Yes ☐ No
4) Do you have allergies? (food, medication, bees, etc.) ☐ Yes ☐ No If YES, please specify: _____
5) Is the student currently taking any medications? ☐ Yes ☐ No PRN medication (i.e. inhalers and EpiPens)

If YES, please list below including dosages and how often. (Include asthma inhalers and EpiPens)

Medical History:

Please check only all the boxes that apply and explain them on the lines below:

- ☐ Hospitalization or Surgery
- ☐ Seasonal / Environmental Allergies
- ☐ Broken bones, Dislocations
- ☐ Muscle or Joint Injuries
- ☐ Neck or Back Injuries
- ☐ Heart Defects / Murmurs
- ☐ High Blood Pressure / Cholesterol
- ☐ Chest Pain during or after exercise
- ☐ Fainting or Blacking-Out
- ☐ Running / Exercise Problems
- ☐ Asthma / Breathing Issues
- ☐ Blood Disorders /Anemia / Sickle Cell
- ☐ Vision Problems (Contacts / Glasses)
- ☐ "Mono"
- ☐ TB or Positive Skin Test
- ☐ Skin Problems (Eczema, Psoriasis)
- ☐ Dental Problems (Pain / Bleeding)
- ☐ Concussions
- ☐ History of Seizures
- ☐ Headaches / Migraines
- ☐ Diabetes/Thyroid/Endocrine
- ☐ Weight or Eating Issues
- ☐ Females: Menstrual problems
- ☐ Stomach Problems
- ☐ Hearing Problems
- ☐ Any other medical problems

Mental Health History:

Please check only all the boxes that apply and explain them on the lines below:

- ☐ Mood Disorder / Depression
- ☐ Anxiety / Panic / OCD
- ☐ Anger / Other behavioral issues
- ☐ Academic Concerns
- ☐ Cutting / Self-harm
- ☐ Learning Disorder / ADD / ADHD / Autism Spectrum
- ☐ Loss / Divorce / Deportation of family members
- ☐ Substance use / Vaping
- ☐ Eating / Significant Weight Loss or Gain
- ☐ Other unlisted concerns

Family History:

Please check only all the boxes that apply and explain on the lines below:

- ☐ Family member with heart disease
- ☐ Family member with high cholesterol
- ☐ Family member with diabetes
- ☐ Family member with mental illness (i.e. Depression, Anxiety,)
- ☐ Family members with alcohol / drug problems
- ☐ Family medical problems not addressed above

6) Has any sudden family member died of heart problems or sudden death before age 50? ☐ Yes ☐ No

Please specify which family member (Maternal / Paternal): _____

This medical history is accurate to the best of my knowledge. I understand that I am required to inform the School Based Health Center if there are any changes in my child's mental or physical health.

Signature: _____ Relationship to Patient; _____ Date: _____

Rev. 07/2026 DPS

CIFC Health

Patient Communication Consent Form

At CIFC Health, we strive to provide you with excellent care and timely communication. By signing this form, you consent to receive messages from CIFC Health, including appointment reminders, scheduling updates, test results, and other healthcare-related information, through the methods below.

Contact Consent

By providing your contact information you give permission to be contacted in the ways you check below:

Cell: _____

☐Text ☐ Non-confidential message ☐ Detailed message ☐ Do not leave message

Home: _____

☐ Text ☐ Non-confidential message ☐ Detailed message ☐ Do not leave message

Work: _____

☐ Text ☐ Non-confidential message ☐ Detailed message ☐ Do not leave message

Email Address: _____

By providing your email address, you will be granted access to the patient portal and consent to receive email communications.

☐ By checking this box I decline access to the patient portal and to receive email messages

Electronic Messaging

☐ By checking this box I acknowledge:

- Message frequency may vary
- Standard message/data rates may apply for SMS
- I may opt out of text messages at any time by replying **STOP**
- Carriers are not liable for delayed or undelivered messages
- Privacy Policy: For more information about how we protect your information, please review our privacy practices available on our website at https://www.cifc.org/home-page/page/website-disclaimer

Authorized Contacts

Authorized people with whom we may share your personal health information (PHI):

Name: _____ **Relationship:**_____

Phone: _____

Share Info: ☐ Emergency Contact Only ☐ OK to share all PHI ☐ OK to share Behavioral Health and Substance Use Disorder information

Name: _____ **Relationship:**_____

Phone: _____

Share Info: ☐ Emergency Contact Only ☐ OK to share all PHI ☐ OK to share Behavioral Health and Substance Use Disorder information

Name: _____ **Relationship**:_____

Phone: _____

Share Info: ☐ Emergency Contact Only ☐ OK to share all PHI ☐ OK to share Behavioral Health and Substance Use Disorder information

CIFC Health

Acknowledgment

I understand that:

- This consent does not expire. I can request changes to my communication preferences and contacts at any time
- CIFC Health will make reasonable efforts to honor my preferences
- Some communications may still be necessary for treatment or operations

Patient Name: _____ **Date:** _____ / _____ / _____

Signature of Patient or Parent/Legal Guardian: _____

Printed Name of Parent/Legal Guardian (if signed above): _____

CIFC Health

Authorization for Consent

SBHC Consent

I give permission to the CIFC Health School Based Health Centers and Connecticut Public Schools to exchange pertinent information to appropriate persons for the purpose of providing healthcare, diagnosis, treatment, and counseling services, as well as maintaining safety in schools. This shared information may include health, academic and special education data needed for treatment/services to the named insurance providers for the purpose of billing.

CIFC Use of Health Information Exchange (HIE):

We participate in one or more secure electronic Health Information Exchanges ("HIEs") that allow authorized health care providers, health plans, and other organizations to share your health information for permitted purposes such as treatment, payment, and health care operations. Sharing through an HIE helps coordinate your care and improve quality and efficiency.

Your information may be shared electronically with other HIE participants, including hospitals, physicians, pharmacies, laboratories, and health plans, and may include information created by us or received from others.

Unless you choose to opt out below, your health information may be shared as described above. You may opt out at any time, except where disclosure is required by law or needed for your care team to obtain information related to your treatment.

☐ **Opt out of CIFC HIE sharing**

Check this box only if you do NOT want your health information shared for the purposes listed above.

Health Information Exchange (Connie):

We participate in Connie, Connecticut's state-designated Health Information Exchange (HIE). Sharing through Connie helps coordinate your care and reduce delays or duplicate testing.

Unless you select one or more boxes below, this information may be shared through Connie as permitted by law. You may opt out at any time at www.conniect.org or by calling **(866) 987-5514.**

Do NOT share the following information through Connie:

☐ HIV/AIDS

☐ Behavioral Health

☐ Substance Use Disorder

Financial Agreement & Assignment of Benefits:

I give CIFC Health permission to send bills for services to Medicare, Medicaid, or any other insurance company for me and my children under age 18 who are listed on the demographic form. I also give CIFC Health permission to share my or my child's health information with the insurance company, which includes mental health care, substance use, or HIV information, if needed for payment.

I understand that I am responsible for paying all charges for services for me and my children under age 18 who are listed on the demographic form. This includes deductibles, co-pays, and co-insurance; services my insurance does not cover; and any amount left after my insurance pays.

I understand that I must notify CIFC Health immediately of any changes in my insurance.

I allow my insurance company to send payment directly to CIFC Health or its providers for services provided to me or my children under age 18 who are listed on the demographic form. If my insurance denies the claim because I am not eligible, my coverage has ended, or for any other reason, I agree to pay the full amount owed as soon as possible.

I understand that CIFC Health offers a sliding fee scale discount program for charges based on my income, and I agree to notify CIFC Health immediately of any changes in my income. I understand that I can talk to the FIA Department to learn more about the sliding fee scale discount program.

CIFC Health

Authorization to Treat:

I give permission to the staff of CIFC Health to provide routine medical, dental, and behavioral health care for me and my children under age 18 who are listed on the demographic form. Care may include tests (including an HIV test), medicines, shots, vaccines, or other treatments that are based on standard medical guidelines but may have some risks. My provider will explain the risks to me in advance. I understand that I have the right to say no to any test, treatment, service, or medicine, as allowed by law. I understand that students and health care trainees may help with my care under the supervision of CIFC Health clinical staff.

Uses and Disclosures of Information and Notice of Privacy Practices Acknowledgment:

I authorize CIFC Health to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to maintain my health information in an electronic health record system and to use secure technology to improve healthcare delivery; (3) to enable CIFC Health to obtain payment for the services it provides to me; and (4) to permit CIFC Health to carry out ordinary health care and business operations such as quality assurance, service planning and general administration.

I am aware that this authorization to use and disclose information may include information regarding: (1) HIV or AIDS; (2) substance use disorder treatment; (3) psychiatric or behavioral health; (4) sexually transmitted diseases; and (5) reproductive health. I am aware and agree that CIFC Health may share information with my other medical providers for medical treatment or with a third party for financial payment through electronic means.

I authorize CIFC Health to request and use my prescription medication history from other health care providers and/or third-party pharmacy benefit payers for treatment purposes. This consent form will remain in effect until the day I revoke consent. To revoke consent at any time, I will speak to the registration manager of the department.

A description of how CIFC Health may use or disclose health information about me, my rights related to my health information and how to file a complaint if I feel that my rights have been violated is in CIFC Health's Notice of Privacy Practices (NPP). My signature/electronic signature below acknowledges that I have been offered or received a copy of CIFC Health's NPP and that I can access a copy any time at https://www.cifc.org/home-page/page/privacy-statement or at any clinic location.

Patient Name: _____ **Date:** _____ / _____ / _____

Signature Parent/Legal Guardian: _____

Printed Name of Parent/Legal Guardian: _____

Patient Bill of Rights and Responsibilities

CIFC Health is committed to providing high quality care that is necessary, responsive, and accountable to the needs of our patients and their families. We are committed to providing our patients and their families with a means to not only receive appropriate health care and related services, but also to address any concerns they may have regarding such services. We encourage all our patients to be aware of their rights and responsibilities and to take an active role in maintaining and improving their health and strengthening their relationships with our health care providers. A written statement of patient rights and responsibilities shall be posted and made available to patients.

We encourage anyone with questions or concerns regarding CIFC Health "Bill of Rights and Responsibilities" to contact an operations manager.

EVERY PATIENT HAS A RIGHT TO:

- Receive high quality care based on professional standards of practice, regardless of their ability to pay for such services.
- Obtain services without discrimination on the basis of race, ethnicity, national origin, sex, age, religion, physical or mental disability, sexual orientation or preference, marital status, socio-economic status or diagnosis/condition.
- Be treated with courtesy, consideration and respect by all CIFC Health staff, at all times, in a manner that respects his or her dignity and privacy.
- Be informed of CIFC Heath's Privacy Policies and Procedures, as they relate to individually identifiable health information.
- Expect that CIFC Health will keep all medical records confidential and will release such information only with his or her written authorization, in response to court order or subpoenas, or as otherwise permitted or required by law.
- Access, review and/or copy his or her medical records, upon request, at a mutually designated time (or, as appropriate, a legal custodian) and request amendment to such records.
- Know the name and qualifications of all individuals responsible for his or her health care and be informed of how to contact these individuals.
- Request a different health care provider if he or she is dissatisfied with the person assigned to him or her by CIFC Health. CIFC Health will use best efforts, but cannot guarantee that re-assignment requests will be accommodated.
- Ask questions and receive a complete, accurate, easily understood and culturally and linguistically competent explanation of (and, as necessary, other information regarding) any diagnosis, treatment, prognosis, and/or planned course of treatment with alternatives (including no treatment), and associated risks/benefits.
- Receive information regarding the availability of support services, including translation, transportation and education services.
- Receive sufficient information to participate fully in decisions related to his or her health care and to give informed consent prior to any diagnostic or therapeutic procedure. If a patient is unable to participate fully, he or she has the right to be represented by parents, guardians, family members or other designated surrogates.
- Refuse any treatment (except as prohibited by law), after being informed of the alternatives and/or consequences of refusing treatment. However, if it is determined that the condition of the patient is of an extremely critical nature, an emergency measure may be taken, without consent, to provide proper patient safety. This may include CIFC Health having to inform the appropriate authorities of this decision.
- Obtain another medical opinion prior to any procedure.
- Be informed if any treatment is for the purpose of research or is experimental in nature and be given the opportunity to provide his or her written informed consent before such research or experiment will begin (unless such consent is otherwise waived).
- Develop advance directives and be assured that CIFC Health care providers will comply with those directives in accordance with law.
- Designate a surrogate to make health care decisions in the event he/she becomes incapacitated.
- Ask for and receive information regarding his or her financial responsibility for the services.
- Receive an itemized copy of the bill for his or her services, and an explanation of charges that will be charged to his/her insurance.
- Request any additional assistance necessary to understand and/or comply with CIFC Health's administrative procedures and rules, access health care and related services, participate in treatments, or satisfy payment obligations by contacting an operations manager.
- File a grievance or complaint about CIFC Health or its staff without fear of discrimination or retaliation and have it resolved in a fair, efficient and timely manner.
- Informed consent for treatment in writing that describes the specific terms for which consent is given (in cases of minors informed consent is given by the legal guardian).

EVERY PATIENT IS RESPONSIBLE FOR:

- Providing accurate personal, financial, insurance and medical information (including all current treatments and medications) prior to receiving services from CIFC Health and its health care providers.
- Following all administrative rules and procedures posted within the CIFC Health facility(s).
- Behaving at all times in a polite, courteous, considerate and respectful manner to all CIFC Health staff and patients, and respecting the privacy and dignity of other patients.
- Familiarizing himself or herself with his or her health benefits and any exclusions, deductibles, co-payments and treatment costs.
- Supervising his or her children while in the CIFC Health facility(s).
- Refraining from abusive, harmful, threatening, or rude conduct towards other patients and/or CIFC Health staff.
- Not carrying any type of weapons or explosives onto the CIFC Health facility(s).
- Keeping all scheduled appointments and arriving on time.
- Notifying CIFC Health no later than 24 hours (or as soon as possible within 24 hours) prior to the time of an appointment that he/she cannot keep the appointment as scheduled. Failure to follow this policy may result in being charged for the visit and/or being placed on a waiting list for the next visit.
- Participating in and following the treatment plan recommended by his or her health care provider, to the extent he or she is able, and working with the provider to achieve desired health outcomes.
- Asking questions if he or she does not understand the explanation of (or information regarding) his or her diagnosis, treatment, prognosis, and/or planned course of treatment, alternatives or associated risks/benefits, or any other information provided to him or her regarding services.
- Providing an explanation to his or her health care providers if refusing to (or unable to) participate in treatment and clearly communicating wants and needs.
- Informing his or her health care providers of any changes in or reactions to medication and/or treatment.
- As applicable, making a good faith effort to meet financial obligations, including promptly paying for services provided.
- Advising CIFC Health of any concerns, problems, or dissatisfaction with the services provided or the manner in which (or by whom) they are furnished.
- Utilizing all services, including grievance and complaint procedures, in a responsible, non-abusive manner, consistent with the rules and procedures of CIFC Health (including being aware of CIFC Health's obligation to treat all patients in an efficient and equitable manner).
- Complying with the smoke-free policy.
- Assisting by alerting staff when another patient is having any difficulty.
- Presenting for treatment not under the influence of illegal drugs or alcohol. Patients presenting under the influence of illegal drugs or alcohol will not be treated.
- As applicable, complying with drug monitoring as requested by their clinician.
- As applicable, not wearing sunglasses during individual or group therapy sessions unless (1) therapy occurs outdoors in a natural setting or (2) the patient has documented medical condition requiring the use of sunglasses indoors.
- As applicable, arranging for childcare of their children over age 1 during their behavioral health treatment sessions. Patients presenting for behavioral health treatment with their provider who have not made adequate arrangements for child care for their children over the age of 1 will not be seen.

ACKNOWLEDGMENT AND SIGNATURE

I acknowledge that I have received, read, and understand the CIFC Health Patient Bill of Rights and Responsibilities.

Patient Name: Date of Birth (mm/dd/yyyy): _____ / _____ / _____

_____

Signature of Patient or Parent/Legal Guardian: Today's Date: _____ / _____ / _____

_____

Printed Name of Parent/Legal Guardian (if signed above):

_____

CIFC Health
CT Institute for Communities =

AGREEMENT BETWEEN OUTPATIENT AND PATIENT OR PARENT/GUARDIAN

Patient Name _____ DOB _____

Parent/Guardian Name	
Address	
Telephone Number(s)	

Person who will transport the client to and from appointments: **N/A** (¨ If same as above, check here.)

Parent/guardian understands that they must remain in the Behavioral Health Dept. while the child is attending an appointment.

Children at the School-Based Health Center: Clinicians will follow the School and school district policy when service is completed at the SBHC site.

I understand that there are not any medical procedures conducted by the behavioral health staff. Should medical assistance be required I will assume responsibility for seeking such treatment. Should an emergency occur, an ambulance will be called.

I understand that no medications will be administered by the behavioral health staff

I have received a paper copy of the Patient Rights and Responsibilities. I have been instructed to contact the site manager if I have any questions.

I have been given a paper copy of the Notice of Privacy Practices.

I understand that all staff are mandated reporters and are required to report suspected child abuse and neglect (as described by CT statutes; 17a-101;). I understand that my confidentiality may be waived if I express an intention to harm myself, harm another, commit a crime, or if I am experiencing child or elder abuse, or am gravely disabled.

Information will be released after signing a release of information form. If I sign a release of information form, I will do so of my own free will. The release will expire within one year; however, I may withdraw the release at any time without prejudice.

I understand that to file a complaint I must register my complaint in writing with the Behavioral Health Site Manager or the Privacy Officer. A complaint form will be provided to me by Behavioral Health staff when requested. I understand that my complaint will be investigated, and I will receive a response within 30 days.

I understand that I am responsible for payment of my session at the time of each session. If I have made payment arrangements, I understand that I am responsible for making such payments. I understand the fee which I will be charged for each session.

I have been provided with the business hours of the behavioral health clinic at CIFC Health, Health Center. I also understand that if I am experiencing an emergency, I should call 911 or go to the closest hospital emergency room.

I understand that when I arrive for my appointment I must check in at the front desk and make a payment (if applicable), and when I am leaving, I must check out at the front desk to make an upcoming appointment.

NOT APPLICABLE TO SBHC

All of the above information was reviewed with me by clinic staff.

_____ _____
Patient Signature (age 5 and older must sign) Date

_____ _____
Parent/Guardian Signature Date

_____ _____
CIFC Health Representative Date

CIFC Health

CT Institute for Communities

120 Main St., Danbury, CT

Pediatric Behavioral Health Department at CIFC Health

INFORMED CONSENT

Patient: _____ DOB: _____

I hereby voluntarily request and authorize CIFC Health Pediatric Behavioral Health to render the psychiatric services listed below, as clinically appropriate, to the child.

Services may include:
Individual therapy
Family therapy
Group therapy
Psychiatric evaluation
Medication evaluation
Care Coordination/Care Facilitation (such as referrals to community programs, insurance or other entitlement assistance, etc)
Telehealth and Telephonic Services: Virtual Behavioral Health services

The individual treatment plan describes in specific terms the treatment for which the consent is given and is signed by patient/guardian.

I understand that my provider is available to answer any questions I may want to ask. I understand that I have the right to question or refuse any treatment at any time.

While receiving services in the Pediatric Behavioral Health Department, a treatment plan will be created that outlines treatment goals, discharge criteria, frequency of services as well as interventions. These will be reviewed with me on a routine basis. I understand that I have the right to request an internal review of my plan of care, treatment, or services.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian Date