Kids Inc.
Helping children develop

Informed Consent for Treatment

I give consent for evaluation and treatment to be provided for myself/my child by (therapist)_____.

- I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.
- The risks, benefits, side effects and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.
- I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.
- I understand that I may terminate treatment at any time.
- I understand that what is discussed in therapy is confidential unless and until I (the client or parent) give consent to its release, with two exceptions. The therapist will need, and is compelled by law, to report to an appropriate other person(s) if:
  1. The therapist believes that I am in danger of hurting myself or someone else, and
  2. If there is reasonable suspicion that a child has been abused or neglected.

My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

_____ _____
Signature of Patient or Parent/Guardian Date

_____ _____
Printed Name Relationship to Patient (if applicable)

_____ _____
Witness Signature Date

OFFICE INFORMATION:

Our office is a teaching facility and it is possible, at times, there will be an intern or other trainee sitting in on sessions. I understand this is a helpful part of my treatment and consent to this.

_____ I DO CONSENT _____ I DO NOT CONSENT

PRIVACY NOTICE

I have received the Kids, Inc. Health System Notice of Privacy Practices. My signature acknowledges I have received the Notice.

SIGNATURE: _____ DATE: _____

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Family Information

Client Name _____ M / F DOB _____ Age _____ Soc. Sec.# _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell _____ Work _____

School _____ Grade _____

Medications _____

Infectious Diseases _____ Allergies _____ Nicotine use _____

Father's name _____ Home Phone _____ Cell _____

Marital Status _____ Soc. Sec.# _____ DOB _____ Email _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Work phone _____

Medications _____

Mother's name _____ Home Phone _____ Cell _____

Marital Status _____ Soc. Sec.# _____ DOB _____ Email _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Work phone _____

Medications _____

Step Parent _____ Soc. Sec. # _____ DOB _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Work phone _____ Cell _____

Medications _____

1) **Sibling Name** _____ DOB _____ M / F AGE ___ Phone _____

Address _____ School _____ Grade _____

2) **Sibling Name** _____ DOB _____ M / F AGE ___ Phone _____

Address _____ School _____ Grade _____

3) **Sibling Name** _____ DOB _____ M / F AGE ___ Phone _____

Address _____ School _____ Grade _____

Emergency Contact: _____

Phone #**:** _____

Primary care physician: _____

Address: _____

Phone #: _____

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Financial Information

REGULAR THERAPY SERVICES: Our intake session is $150.00. Each succeeding session is $135.00 for 38-52 minutes or $150.00 for 53+ minute session. Any other payment or fee arrangement must be worked out before the end of the first meeting.

INSURANCE INFORMATION / THIRD PARTY PAYMENT: We are licensed mental health providers so many insurance plans will help pay for therapy and other services we offer. You may obtain benefit information from the customer service number on your insurance card or from your agent. **Your insurance co-pay must be made at each visit**. There is a possibility that your health insurance plan will not cover outpatient mental health services. In either case, **the financial responsibility for services is yours as a client/parent**. Please note: Occasionally contact with collateral professionals, e.g., school counselors or teachers, may be needed and most insurance companies do not cover these expenses. This will require us to bill you directly.

THE KIDS INC. CANCELLATION POLICY requires that 24-hour notice be given if it is necessary to cancel or change an appointment. At the discretion of the doctor or therapist, the following charges may be applied: First late cancellation or failure to show– $0 charge; 2nd late cancellation or failure to show – $70 charge; 3rd or more cancellations or failure to show - $135 will be charged each time. I also understand that my insurance will not cover cancellation charges.

PATIENT/PARENT/GUARDIAN AGREEMENT:
Kids, Inc. has notified me that there is the possibility that outpatient mental health services may not be a covered benefit by my health insurance. **If my insurance is not in effect today or a service is not a covered benefit, I agree to be financially responsible for the charges that occur today and any subsequent charges that may occur.**

I give this office permission to release any information to my insurance company during treatment of me or my family, which is necessary to obtain authorizations or support any insurance claims on this account and secure timely payments due to the assignee or myself.

ASSIGNMENT OF BENEFITS:
I hereby assign medical benefits, including those from government-sponsored and other health plans to Kids, Inc. A photocopy of this assignment is to be considered as good as the original. I agree to the above statements and attach my signature below.

Client (or parent/guardian signature) _____ Date _____

Printed name _____

PLEASE MAKE SURE WE HAVE A COPY OF YOUR INSURANCE CARD

Insurance Company_____

Cardholder name _____ Employer/Group Name _____

Effective Date of coverage_____ Family Coverage Yes ☐ No ☐

Co-Pay per visit $_____ Deductible $ _____ per person _____ per family _____

Is physician referral required? Yes ☐ No ☐

Is authorization required? Yes ☐ No ☐ If yes, authorization #? _____ # of visits?_____

7133 W. 95th St, Suite 216 • Overland Park, KS 66212 • (913) 617-9294
www.kidsincplaytherapy.com

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Authorization to Obtain or Release Confidential Records and Information

Client Name: _____ Date of Birth: _____

I hereby authorize the following person or agency to share written and oral information (two-way or reciprocal release) about my needs and the services I receive:

Name(s) (i.e. counselor/teacher): _____

Facility (i.e. school/office/hospital): _____

Address: _____

City, state, zip: _____

Phone: _____ Email: _____

With (name of therapist) _____

Please forward the records to Kids Inc. at the following address:
7270 West 98th Terrace, Suite 105, Overland Park, KS 66212 • phone (913) 617-9294

The information shared or released is for the following purpose(s):

____ Further mental health evaluation, treatment, or care ____ Educational Program Planning

These records concern the time between _____ and _____.

The information to be disclosed is marked by an X in the boxes below, and the items not to be released have a line drawn through them.

____ Medical history and evaluation(s)
____ Developmental and/or social history
____ Treatment history
____ Mental health evaluations
____ Educational records
Other:_____

My signature below acknowledges my understanding of the following:

I understand I am authorizing the release of confidential records and information. I understand their content and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may revoke my consent at any time within 90 days except to the extent that action based on this consent has already been taken. I understand that I have the right to receive a copy of this Release and to request to view the information released by this consent.

This consent will expire automatically after 360 days from the date on which it is signed, or upon fulfillment of response from above named facility or person(s) for the purposes stated above.

_____ _____ _____
Signature Printed name Date

_____
Relationship to Client

Kids Inc.
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Confidential Exchange Of Information with
Primary Care Physician or other Behavioral Health Clinician/Facility

Client/Patient

Name: _____ DOB: _____

Primary Care Physician or other Behavioral Health Clinician/Facility

Name: _____ Office or Facility: _____

Phone: _____ Fax: _____

Address: _____
(Street) (City) (State) (Zip)

Consent to Release Information

Communication between behavioral health providers and your primary care physicians or other behavioral health providers is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary.

I, Do_____/Do Not _____, authorize Kids Inc. to release information related to my evaluation and treatment to the physician/clinician named above. This consent will last one year from the date signed and I understand that I may revoke my consent at any time.

_____
Responsible Party's Signature Printed Name of Signee Relationship to Client Date

Dear Dr. _____;

I'm writing to notify you that your above named patient was seen by me for a mental health evaluation and therapy. I look forward to working with you in the care of this client during their on-going therapy. Please let me know if you would like further information. I can be reached during my office hours or by confidential voicemail, if you prefer to leave a message.

Specific Information or Concerns:

Thank you for your assistance in coordinating care for this client.

Sincerely,

Name: _____ Phone: _____ Date Sent: _____

PLEASE DO NOT SEND MEDICAL RECORDS UNLESS SPECIFICALLY REQUESTED.

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Credit Card Payment Policy

In an attempt to keep our clients' accounts up to date, we have implemented a very successful system of payment. By having your credit card information on file, we can efficiently update your account after each session.

In addition, the Kids Inc. cancellation policy requires that 24-hour notice be given if it is necessary to cancel or change an appointment. At the discretion of the doctor or therapist, the following charges may be applied:

First late cancellation or failure to show for an appointment – $0 charge
2nd late cancellation or failure to show – $70 will be charged
3rd or more cancellations or failure to show - $135 will be charged each time

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I have been made aware of this policy and understand that my credit card may be charged for these fees. I also understand that my insurance will not cover cancellation charges.

I authorize Kids Inc. to charge this account for co-pays and cancellation fees as explained above.

Credit Card Information--

Card Number_____

V/MC Expiration Date:(Mo./Yr.)_____ 3-digit CID_____

Name of Card holder:_____

Address of Card holder: _____

_____ _____
Signature of Cardholder Date

If you have any question about this policy, please discuss it with your therapist.

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