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20231 Paint Boulevard
Shippenville, PA 16254
(814) 226-1159
Fax (814) 227-2876

850 Leonard Street
Clearfield, PA 16830
(814) 205-4004
Fax (814) 205-4013

CHILD CONSENT TO TREATMENT

I acknowledge that I have received, have read and understand Client's Rights and Responsibilities and Statement of Patient Grievance Procedures. I have had all my questions fully answered.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedure provided by this therapist.

I am aware that I may stop treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court ordered I will have to answer to the court.) I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged for that appointment. I am aware that an agent of my insurance company or other third-party payer may be given information about the types, costs, dates, and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop treatment. I understand that I am responsible for any amount not covered by insurance. I understand that the Program may change their fee schedule at any given time.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Child's Printed Name | Child's Signature if 14 Years of Age or Older

_____ _____

If Child Under 14 Parent/Guardian Signature | If Child Under 14 Parent/Guardian Signature

If one parent's signature is not present please explain why_____

_____

I the therapist have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Client Name: _____ Client ID:

Therapist's Signature Credentials Date

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CHILD HISTORICAL INFORMATION

Client Name:_____ DOB:_____

FAMILY OF ORIGIN HISTORY: Date:_____

Relative	Name	Current Age (age at death)	Occupation	MH, D&A or Criminal Issues
Father				
Mother				
Brother (s)				
Sister (s)				

1) Has the child ever been placed out of the home: _____ Yes _____ No

If yes, please explain:

Date Placed	Date Released	Placement Name & Address	Reason Child Placed	Progress Made in Placement

2) Has anyone other than the biological parents had legal custody of the child: _____ Yes _____ No

If yes, please explain:

Date Custody Granted	Date Custody Released	Name, Address, Phone of Person Or Agency Granted Custody	Reason Custody was Granted

EDUCATIONAL HISTORY:

Date From:	Date To:	Name of School or College	Special Classes (Yes or No)	Behavior Problems (Yes or No)	Did Child Complete

1)Does the child have an Individualized Education Plan (IEP) in school: _____ Yes _____ No

2)Does the child have any services in place to assist with their learning: _____ Yes _____ No

If yes, please explain:_____

_____

SEXUAL HISTORY:

1) Describe any sexual activity the child is engaging in (exploration with other children, masturbation, sexually acting out):_____

_____

_____

2) Has the child had any access to pornography through videos, magazines, tv, internet ___Yes ____No
If yes please explain:_____

_____

3) Are there any indications that the child may have observed any sexual acts: ____Yes ____No
If yes please explain:_____

_____

4) Does the child have a history of being a victim of sexual abuse: ____Yes ____No
If yes please explain:_____

_____

_____

MEDICAL HISTORY:

1) List any significant medical issues:_____

_____

2) Has the child ever been diagnosed with an infectious disease: ____Yes ____No

If yes, please describe diagnosis and treatment regimen:_____
_____
_____

Treating Physician's Name	Phone Number	Address	Frequency of Visits

3) Has the child ever received any drug or alcohol treatment: ____Yes ____No
If yes, please provide treatment name and address, frequency of treatment and when that treatment took place:_____
_____

4)Has the child ever been pregnant: _____ Yes _____ No

5)Has the child ever suffered from any food, drug or environmental allergies:_____Yes _____ No
If yes please describe what the child is allergic to and what adverse reactions are experienced:_____
_____
_____

DEVELOPMENTAL HISTORY:

Child's birth weight:_____ Child's birth length:_____

Was the child premature: _____Yes ____No Was the child born cesarean: ____Yes ____No

Age child toilet trained:_____ Age child began crawling:_____

Age child began walking:_____ Age child began forming words:_____

Does child experience any sleep disturbances: _____Yes _____No
Has the child experienced any physical delays: _____ Yes _____ No
Has the child experienced any social delays: _____ Yes _____ No

If you answered yes to any of the three questions above, please explain:_____
_____
_____

MENTAL HEALTH HISTORY:

1) Has the child ever received any mental health treatment in his/her lifetime: ____Yes ____No
If so please answer the following questions:

Date From:	Date To:	Name of Provider, Address, Phone Number	Service Received	Child's Diagnosis

RELIGIOUS/SPIRITUAL/CULTURAL HISTORY:

1) Does the child currently practice any religion or belong to any spiritual organization: __ Yes __ No
If yes, please describe: _____
_____

2) Does the child currently belong to any cultural organizations or practice any specific cultural beliefs:
____ Yes ____ No
If yes, please describe: _____
_____

LEGAL ISSUES:

1) Is the child currently involved in the court system for any criminal or civil proceedings: __Yes __No
If yes, explain:_____
_____

2) Has the child ever been or are they currently involved with juvenile probation: ____ Yes ____ No
If yes, please explain:

Date From:	Date To:	County, Address, Phone Number	Reason for Involvement

3) Has the child or child's family been involved with Children & Youth Services: ____ Yes ____ No
If yes, please explain:

Date From:	Date To:	County, Address, Phone Number	Reason for Involvement

SOCIAL SUPPORTS:

1) List all the social supports available for the child: _____
_____

2) Do you feel these supports are adequate: ____ Yes ____ No

STRENGTHS AND WEAKNESSES:

1) List the child's strengths:_____
_____
_____

2) List the child's weaknesses:_____
_____
_____

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AUTHORIZATION TO DISCLOSE INFORMATION TO PRIMARY CARE PHYSICIAN & BEHAVIORAL HEALTH PROVIDER

Client's Name:_____ DOB:_____
Address:_____

Sometimes you need to see a number of different providers to get all the services you require. This includes behavioral health providers and physical health providers. All of your providers and managed care organizations should work together to provide you with the best possible care, but your providers and managed care organizations can only talk to each other with your permission. Please consider giving this permission. By letting your providers and managed care organizations talk to each other, you can verify that all your medications are safe to take together, avoid repeat tests and get the help you need.

By signing this form you are telling us that it is okay for your primary care provider, your behavioral health providers, your physical health managed care organization and your behavioral health managed care organization to share health information about you for the purpose of planning and coordinating your health care. This helps your providers and managed care companies work together to take better care of you.

If you do not sign this form, your benefits will remain the same. Some information may still be shared even if you do not sign this form.

☐ I agree that my information may be shared with my Primary Care Physician listed below:

Client Name: _____ Client ID:

PCP Name:_____ Phone:_____

Address:_____

☐ I agree that my information may be shared with my Behavioral Health Provider listed below:

BHP Name:_____ Phone:_____

Address:_____

☐ I agree that my information may be shared with my second Behavioral Health Provider listed below:

BHP Name:_____ Phone:_____

Address:_____

I agree that my information can be shared with my physical health and behavioral health Managed care organizations below. Please check your managed care organization(s):

☐ Community Care Behavioral Health, Inc.
☐ Community Care Behavioral Health Org.
☐ Community Behavioral HealthCare Network of PA
☐ Magellan Behavioral Health
☐ Value Behavioral Health
☐ Highmark Blue Cross Blue Shield
☐ Keystone Mercy Health Plan
☐ UPMC Health Plan
☐ Other_____

☐ Aetna
☐ AmeriHealth Mercy
☐ Coventry Health Care
☐ DPW Intense Medical Case Mgt.
☐ Gateway Health Plan
☐ Health Partners
☐ United Healthcare Community Plan
☐ APS Healthcare (Access Plus)
☐ Other_____

Signing below permits general physical and mental health information to be shared. And if my records have drug/alcohol information or HIV related information, I agree to share that information as shown below:

☐ My records contain drug/alcohol information
☐ Yes I agree to share that information ☐ No I do not agree to share that information

☐ My records contain HIV/AIDS information
☐ Yes I agree to share that information ☐ No I do not agree to share that information

I can revoke or cancel this release at any time. This will not take back information that was Already shared but will ensure that no further information is shared. This release is valid for

Client Name: _____ Client ID:

one year from the date signed unless it is revoked by you in writing.

Client's Name	Client's Signature	Date

Signature of Parent/Guardian	Relationship to Client

Therapist's Signature	Credentials	Date

Project Point of Light

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CLIENT'S RIGHTS

*Be treated with dignity and respect.
*Fair treatment; regardless of race, religion, gender, ethnicity, age, disability or source of payment.
*Have treatment and other patient information kept private. Only when permitted by law, may records be released without patient's permission.
*Easily access timely care.
*Know about their treatment choices, regardless of cost or coverage by their benefit plan.
*Share in developing their care plan.
*Given information in a language they can understand and provided with a clear explanation of their condition and treatment options.
*Given information about their insurance coverage, its practitioners, services and role in treatment.
*Provided information about clinical guidelines used in providing and managing their care.
*Ask their provider about their work history and training and be able to request certain preferences in a provider.
*Given information about advocacy and community groups and prevention services.
*Freely file a complaint or appeal and be provided the information on how to do so.
*Know their rights and responsibilities in the treatment process.
*Receive services that will not jeopardize their employment.
*Have provider decisions made about their care without regard to financial incentives.

CLIENT'S RESPONSIBILITIES

*Treat those giving them care with dignity and respect.
*Give providers information they need to deliver the best possible care.
*Ask questions about their care to assist in understanding their care.
*Follow the treatment plan and agreed upon medication plan.
*Tell their provider and primary care physician about medication changes, including medication give to them by others.
*Keep their appointments. Cancellations without 24 hour notice, that was not a result of a serious emergency, may result in being charged for the appointment.
*Let providers know when the treatment plan is not working.
*Paying fees or deductibles at the time of treatment. Let providers know about problems with paying fees.

Client Name: _____ Client ID:

*Report abuse or fraud and openly report concerns about the quality of the care they receive.

My signature below shows that I have been informed of my rights and responsibilities and that I understand this information.

_____ _____
Client's Signature (Parent/Guardian Signature if Child Under 14) Date

The signature below shows that I have explained this statement to the patient and have offered the member a copy of this form.

_____ _____
Therapist's Signature Credentials Date

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STATEMENT OF PATIENT GRIEVANCE PROCEDURE

By definition a grievance is what you file if you are not satisfied with a decision the Program has made about your behavior/mental health care. You may file a grievance if you feel your rights have been violated because the agency has either denied you a service or approved a service less or different from what you requested. You have thirty days from the date that a decision about your care has been made to file a grievance. The agency encourages that you first try to resolve the matter with your primary therapist. If you are not satisfied with the response from your primary therapist the agency suggests you bring the matter to the Program Administrator. If you are not satisfied with that decision made the agency invites you to submit an internal grievance in writing to the Program Director at the following address:

Project Point of Light, Inc.
Brenda Manno, Program Director
20231 Paint Boulevard
Shippenville, Pennsylvania 16254

If you grievance involves non-emergent care the Program Director will review it within five business days and respond to your grievance within five business days from the time of review. If your matter is of an emergent nature the Program Director will review and respond to your grievance within twenty four business hours. If you are not satisfied with the agency's response to your initial grievance, you may contact your insurance agency directly to file a grievance.

Client Name: _____ Client ID: