## University of Maryland’s Care Clinic

## Consent for Child & Adolescent Treatment

# Consent for Treatment

I, the undersigned, am the legal guardian of Click or tap here to enter text. (date of birth Click or tap to enter a date.). I hereby authorize University of Maryland Center for Families’ Care Clinic to provide my child the following services, as needed:

* Comprehensive Assessment (Intake evaluations, psychological evaluations, and/or psychiatric evaluations)
* Mental Health Treatment (individual, family, and/or group counseling)
* Psychiatric Consultation (can include medication management)

It is my understanding that treatment consent may be revoked at any time by any of the child’s legal guardians by notifying my child’s therapist.

Initial: [ ]

# Telehealth

Some or all services may be provided by Telehealth if needed and clinically appropriate. Telehealth treatment (also called teletherapy or tele-mental health) is when a medical or mental health professional and patient(s)/client(s) use videoconferencing software or phone instead of meeting face-to-face. This allows clients to access medical and mental health services when meeting in person is not possible. Care Clinic staff may at times use telehealth to provide evaluation, therapy, and/or other services to you/your child.

Risks to telehealth may include:

* The possibility of technological difficulties, which may delay or disrupt treatment
* A breach of information beyond the provider’s control (e.g., if your family member overhears all or part of your session; if a “smart” device [e.g., Apple’s Siri, Amazon’s Alexa] is present and not turned off)
* Difficulty interpreting body language and other non-verbals
* Limited access to immediate resources if you/your child is in crisis (e.g., experiencing suicidal or homicidal thoughts)

Telehealth agreement:

* My provider will take all appropriate steps to protect my/my child’s confidentiality on their end, but it is my responsibility to protect my/my child’s confidentiality on my end by finding a private, quiet, and distraction-free place to hold the session.
* I/my child must be physically in the state of Maryland to engage in telehealth and will cancel/reschedule if location is elsewhere.
* My telehealth sessions will ***not*** be recorded by my provider without my consent; nor will I record them on my end or allow someone other than the client to be present or to hear the session without knowledge and consent of the provider. I will also turn off any smart devices (e.g., Apple device with Siri, Google assistant, Amazon Alexa) that’s in the immediate area.
* I/my child will be fully dressed, will not “bring” or use items that aren’t part of the session (texting/messaging with others, paying games on device, etc.).
* I must provide the therapist with the address and emergency contact information for telehealth sessions.

Initial: [ ]

# Expectations of Services

People seek mental health treatment for a variety of reasons. Successful mental health services can have many benefits, including (but not limited to) the following:

* Improved social relationships
* Better control of emotions and behavior
* Decreased suicidal/homicidal ideation
* Improvement of other symptoms

Often times, however, as treatment progresses, there may be momentary periods of distress due to (among other things):

* Changes in routine
* Homework assignments
* Challenges to core beliefs
* Processing of trauma

Although the client may experience some distresses, it is important to note that this is part of the therapeutic process. In many cases, this discomfort is normal and expected. An important part of the therapeutic process is open communication between the client and clinician. Thus, it is the client’s responsibility to communicate any concerns or other feedback as they arise. In turn, the clinician(s) involved will do their best to accommodate for these concerns.

Initial: [ ]

# Student Clinicians

Along with the goal of providing high-quality services, the Care Clinic also has a goal of providing valuable training, supervision, and consultation to its therapists and medical students/residents. Observations are a standard part of our practice, however if you do not wish to be observed you may let your therapist know at any time. Also, some or all of your clinical services might be provided by a graduate student clinician. All graduate students are supervised and operate under the licenses of licensed mental health professionals. Current supervisor credentials and contact information are as follows:

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| --- | --- | --- |
| April Rectanus, EdD, MA, LCPCClinical Assist Prof; Clinical DirectorLicensed Clinical Professional Counselor(MD LCPC License # LC2018)arectanus@som.umaryland.edu410-706-1142 | Randy Chang, Psy.D.Clinical Assistant ProfessorLicensed Psychologist(MD Psychologist License #04699)rkchang@som.umaryland.edu410-706-5718 | Sarah Jordan, LCPCCare Clinic TherapistLicensed Clinical Professional Counselor(MD LCPC #LC9205)sarah.jordan@som.umaryland.edu410-706-5711 |

Initial: [ ]

# Confidentiality of Services:

# Patients are entitled to the confidence that they may speak freely and their privacy will be protected. We have an ethical and legal responsibility to maintain and protect confidentiality. For children/adolescents in treatment, although periodic and general updates will be provided to caregiver(s)/legal guardians, the child/adolescent may discuss with the clinician how much or which portions of information will be shared with the caregiver(s). We will not release information to any party unless a specific “Release of Information” form is signed. There are, however, a few circumstances in which confidentiality cannot be maintained. The most common instances are:

* If you/your child presents a danger or threat to self or someone else, we are obliged to contact others, including law enforcement authorities and emergency medical personnel, as appropriate.
* If we become aware of the abuse or neglect of child, senior/elder or any other vulnerable person, whether past or present, we are under legal obligation to contact the proper authorities.
* When there is involvement with a Court of Law, records may be subpoenaed and/or a judge may court order disclosure from the record if it is determined that the clinical record should be considered as a factor in the case.
* Clinical information can and generally will be shared among service providers at the Care Clinic, unless otherwise specified.
* To make sure that therapists are doing the best job possible, they may talk with other clinicians about their work and get their ideas. If we are getting help from another clinician who doesn’t work at the Care Clinic, we won’t tell them anything about you/your child that would allow them to figure out who you are.

Initial:[ ]

# Record-Keeping and Maintenance:

All paper files are kept within the Care Clinic and will not leave clinic grounds without expressed written permission of the client(s). Should a therapist leave the clinic, the client files will remain with the Care Clinic, as opposed to traveling with that therapist. Electronic files are stored on a HIPPA-compliant online database, Apricot. In cases of Family Therapy, there is a possibility that family members’ names might be included within the file, though every effort will be made towards minimizing the amount of personal information contained in that file. If a client or caregiver wishes to obtain a copy of records, a written request for records is required. As is the general standard of practice, the clinician will review the request, and depending on the nature of the request, the clinician may elect to instead provide a written summary of the file. Records will be provided within 30 days of the request.

Initial: [ ]

# Attendance Policy

I received and have read the attendance policy.

Initial: [ ]

# Contact with your therapist:

All therapists can be reached at 410-706-4869 or on their direct lines and have confidential voicemail. Therapists also have Google Voice that they use when working out of the office and for texting. Please note that Google Voice is not HIPPA-compliant, therefore no personal information should be included. Texting and email may be used for scheduling purposes only. For all other issues please call the therapist or speak to them during the session. Calls, texts, or emails will only be returned during the therapist’s business hours. For emergencies after hours, please call 911, your local crisis response number, or go to the nearest emergency room.

Phone/voicemail: All therapists can be reached at 410-706-4869 or on their direct office lines. If a voicemail is left on a therapist's office line, they will be the only one to hear it. Your therapist will need to call you at times and may also need to leave voicemails.

[ ] I consent to receive phone calls and voicemails at a number I have provided.

[ ] I consent for my child to receive phone calls and voicemails at a number I have provided.

Email: University has several safeguards in place to protect confidentiality - though it cannot be guaranteed. You and your therapist should limit the information communicated via email.

[ ] I consent to receive emails at an email address I have provided.

[ ] I consent for my child to receive emails at an email address I have provided.

Text: Texting is not considered HIPAA-compliant, so confidentiality cannot be guaranteed. Therapists have Google Voice numbers which they use when out of the office and for limited text communications, such as appointment reminders, sending resources (e.g., websites, homework assignments), and brief check-ins. Information sent via text should be carefully considered and private information limited as much as possible.

[ ] I understand that texting is not HIPAA-compliant but consent to appointment reminders and other limited text communications via my therapist's Google Voice number. I will not include protected health information and my therapist will do the same.

[ ] I consent for my child to receive text messages at a number I have provided.

Lastly, please know that your therapist will only respond to communications during their work hours. For emergencies after hours, please call 911, your local crisis response number, or go to the nearest emergency room.

[ ] I understand that my therapist is not available outside of their work hours and agree to call 911, a crisis line, or go to an emergency room in a crisis.

Initial: [ ]

My signature below indicates I have read and understood the above and am in agreement with these stipulations.

Click or tap here to enter text. Click or tap to enter a date.

Signature of child or adolescent Date

Click or tap here to enter text. Click or tap to enter a date.

Signature of Parent or Guardian Date

Click or tap here to enter text. Click or tap to enter a date.

Signature of Witness Date