Consent to Treatment, Collaboration with Providers, and Collaboration with Family Members

Client Name: ____ Date of Birth: ____________________

Address: ____

Parent/Guardian Names:____

Phone Numbers and Email Addresses: ____

____

Both legal guardians/parents must initial in the highlighted spaces below and sign names in the highlighted space at the end of the document.

_______ _______ I, the client/client's guardian, agree to meet with my Daybreak Therapy Solutions therapist at the appointment times and places we agree on, starting today. With enough knowledge and understanding, and without in any way being pressured, I enter into treatment with this therapist and this business. I understand that I, as the client, am a full partner in my therapy. My honesty and effort are essential to my success. I will keep my therapist fully up to date about any changes in my feelings, thoughts, and behaviors. I acknowledge that in the course of therapy, I may become aware of additional problems of which I was not previously aware. I agree that if this occurs, I will share these problems with my therapist. We will periodically evaluate progress and make changes in the treatment plan as needed. I agree to share suggestions and concerns about my counseling as they arise such that my clinician can make necessary adjustments. I understand that I may stop treatment at any time and acknowledge the recommendation that I meet with my therapist one last time for resolution and closure if I do decide to stop treatment.

_______ _______ I, the client/client's guardian, agree to provide at least 24-hour notice when I need to cancel an appointment, whenever possible. I understand that after the first same-day cancellation or no-show, I will be charged a $50 fee that must be paid before I can attend my next appointment. (If the client has Medicaid, the business cannot charge a cancellation fee; however, clients will be discharged after two same-day cancellations or no-shows). I understand that regardless of advance notice, if I miss more than 50% of my scheduled appointments, I will be removed from recurring appointments, and will need to call or utilize the portal to fit into cancelation or flex spots. Additionally, as after school/after-work appointments are in high demand, one last-minute cancellation or no-show will result in the surrender of the after-school/after-work time slots.

_______ _______ I, the client/client's guardian, understand that the self-pay rate at Daybreak Therapy Solutions is $125 for the first session and $100 for subsequent sessions. With my permission, Daybreak Therapy Solutions will bill my insurance; I understand that I am responsible for my copays and for any denials by my insurance company. I understand and accept that I am responsible for payment at the time of service. I am responsible for communicating with my clinician if I am having trouble meeting my financial responsibilities. I understand that if my outstanding bill reaches $250, Daybreak Therapy Solutions has the right to discontinue services and provide me with appropriate referrals. Daybreak Therapy Solutions accepts payments in the form of cash, check (made payable to Daybreak Therapy Solutions LLC), or credit card. I understand that depending on the time of my appointment (i.e. after front-desk hours), I may be required to keep a credit card on file for payments, and that refusal to do so may result in discontinuation of services.

_______ _______ I, the client/ client's guardian, understand that I am responsible for arriving on time to appointments. I understand that if I arrive more than fifteen minutes late my clinician will not be able to see me. I further understand that appointment reminders are sent as a courtesy and that I should not rely solely on these text message reminders to remember my appointments. I understand that chronic tardiness may result in me being taken off recurring spots or discharged with referrals to other providers.

_______ _______ I, the client/client's guardian, authorize Daybreak Therapy Solutions to communicate with the following insurance companies. (Please write the insurance company, subscriber ID, group number, subscriber name, and subscriber date of birth.)

Insurance Company: ____________________________ Member ID: ______________________

Member Name: ______________________________ Member Date of Birth: _______________

Group Number: _____________________________ Plan Name: _______________________

_______ _______ I, the client/client's guardian, authorize Daybreak Therapy Solutions to communicate with the following individuals who are important to me regarding my diagnoses, treatment, and progress. I understand that the purpose of this release is to assist with my treatment by improving communication between my treatment team and the important people in my life. This release will expire one year after my final session at Daybreak Therapy Solutions. (Please write to family members or friends who you consider *integral to your life and recovery* that you want included in your treatment; also include their relationship to you and contact information. If you do not currently want anyone included in your treatment, leave blank.)

Name: ________________________ Relationship: ______________ Phone: _______________

Name: ________________________ Relationship: ______________ Phone: _______________

_______ _______ I, the client/client's guardian, authorize Daybreak Therapy Solutions to contact the following individuals in the case of an emergency. An emergency is defined in this situation as any situation in which I am being transferred to a medical facility/ emergency room or in which my therapist believes I am in danger or at risk.

Name: ________________________ Relationship: ______________ Phone: _______________

Name: ________________________ Relationship: ______________ Phone: _______________

_______ _______ Physical health can be an important factor in the emotional well-being of an individual. I, the client/client's guardian, understand that Daybreak Therapy Solutions recommends that I receive a physical examination if I have not done so in the past year. I also agree to provide my clinician with a list of the medications I am taking. Because I believe it is in my best interest, I hereby authorize the release of information between Daybreak Therapy Solutions and the following providers: (*Please list primary care physicians, psychiatrists, neurologists, other medical specialists, other therapists, and schools/ teachers/ principals/ counselors*. The client may be asked to complete a separate release for individual providers.)

Primary Care Physician/ Pediatrician: ______________________________ Phone: _______________

Psychiatrist: ____ Phone: _______________

Other Therapists: _____________________________________ Phone: _______________

Other Physicians: _____________________________________ Phone: _______________

School: ____ Phone: _______________

Teacher: _______________________________ Email: ___________________________

DCFS Caseworkers: ____________________________________ Phone: _______________

_______ _______ I, the client/ client's guardian, understand that Daybreak Therapy Solutions provides therapeutic services and mental health care, and that Daybreak Therapy Solutions was not established with the purpose of testifying for clients in court. I understand that my therapist's responsibility is to the client and the client's recovery, and I agree that I am not obtaining services from Daybreak Therapy Solutions with the purpose of having an expert witness in upcoming court proceedings. I understand that Daybreak Therapy Solutions adamantly opposes getting involved in court cases as it interferes with the therapeutic relationship; if such a situation arises, Daybreak Therapy Solutions will provide a list of referrals for court-related services. Additionally, if I choose to subpoena my therapist to a court proceeding despite these objections, I understand that the cost involved is $2500 for the first day, with $1000 of that to be paid by five business days prior to the court date and the remaining balance one business day before court. If my therapist is needed for more than one day of court, the cost will be $1000 for each additional day. I understand that my therapist is needed for a deposition, the cost involved is $350 per hour. I understand that my therapist *will not appear in court* without a subpoena or summons. I understand that failure to make the outlined payments will result in either a refusal to appear in court or my information being sent to debt collections.

_______ _______ I, the client/client's guardian, understand that if I choose for my therapist to communicate with another provider or legal entity regarding a court case, there is a flat fee of $50 for a verbal conversation or brief email update. Written reports and summaries for the purposes of court or legal matters have a flat fee cost of $300 per report.

_______ _______ I, the client/client's guardian, understand that on my request, or the request of any caregiver with guardianship, Daybreak Therapy Solutions will provide a summary of treatment to include date of assessment, diagnoses, treatment goals, prescribed frequency of appointments, appointment dates, and attendance. I understand that in order to adhere with the Social Work Code of Ethics, Daybreak Therapy Solutions works diligently to protect the confidentiality of clients and clinical documentation, and that even with consent, my chart will not be released without a subpoena. I further understand that the practice/therapist is not legally allowed to communicate with anyone without express written permission from a legal guardian (this includes stepparents, partners of parents, grandparents, extended family, etc.)

_______ _______ I, the client/client's guardian, understand that Daybreak Therapy Solutions believes that recovery is a family process and involves efforts and at times changes, in all areas of family life. As such, I understand that at times Daybreak Therapy Solutions may recommend that one or both parents (either the client, or the parent(s) of a client) attend offered parenting classes. I acknowledge that this is not indicative of a perceived parenting deficit, but rather indicative of a belief that the family as a whole would benefit from additional skills. I further accept that depending on the severity of a situation, my clinician has the right to state that parenting classes are imperative for continued participation in Daybreak Therapy Solutions' therapy programs.

_______ _______ I, the client/client's guardian, understand that Daybreak Therapy Solutions believes in the inherent worth of every person, and Daybreak Therapy Solutions is committed to providing a physically and mentally safe and judgment-free zone for health and wellness. As such, I understand that I may not bring any weapon onto the premises. I additionally acknowledge and accept that slurs, discriminatory or derogatory language or behaviors, foul language, insults, and threats will not be tolerated at Daybreak Therapy Solutions, and that the provider and company have the right to discontinue my treatment, and remove and/or ban me from the company and premises if I exhibit these behaviors.

_______ _______ I, the client/ client's guardian, understand that Daybreak Therapy Solutions utilizes animals for therapeutic purposes, and that all animals at Daybreak Therapy Solutions are flea and tick-free, disease-free, current on immunizations, and safely trained. I agree that I will report to my clinicians any allergies I have such that staff can ensure an animal-free office for our sessions. I acknowledge and accept that Daybreak Therapy Solutions considers these animals as part of our Daybreak family, and that taunting, teasing, or aggression towards the animals will not be tolerated, and may result in discontinuation of services if the behavior does not change after warnings. I additionally understand that I am welcome to bring my own (small) animals to Daybreak Therapy Solutions as long as they are also flea and tick-free, disease-free, current on immunizations, and appropriately trained (do not exhibit aggression and are quiet). I understand that Daybreak Therapy Solutions has the right to prohibit my pets (does not apply to service animals) from accompanying me to my appointments if they are disruptive in any way.

_______ _______ I, the client/client's guardian, understand that my clinician is a staff member at Daybreak Therapy Solutions, LLC and under the supervision of Clinical Director Josie Bridges, LCSW and CEO/Owner Melissa Sepeda, LCSW-BACS. As such, I understand that during staff meetings, my clinician may share information with other clinicians at Daybreak Therapy Solutions in collaboration to maximize my benefits of treatment. I understand that these clinicians are bound by the same laws of confidentiality as my therapist, and I consent to this confidential collaboration between clinicians.

_______ _______ I, the client/client's guardian, understand that Daybreak Therapy Solutions, LLC is considered a learning institution and contracts with Louisiana State University as an internship placement. As such, an intern may at times join in my therapy sessions with my established clinician for observation and/or co-facilitation. I understand that Daybreak Therapy Solutions requires clear federal background checks on all interns placed at Daybreak Therapy Solutions and that the interns are bound by the same laws of confidentiality as my therapist.

_______ _______ I, the client/ client's guardian understand that material revealed in therapy will remain strictly confidential except for material shared with colleagues at Daybreak Therapy Solutions (for treatment purposes), and under the following circumstances, in accordance with state law: (1) The client signs a written release of information indicating informed consent of such release. (2) The client expresses intent to harm him/herself or someone else. (3) There is reasonable suspicion of abuse/neglect against a minor child, elderly person (60 or older), or dependent adult. (4) A court order is received directing the disclosure of information. (5) When therapy is court-ordered. I understand that Daybreak Therapy Solutions will consult with the client when possible and clinically appropriate regarding mandated disclosures. *(Please see below for more information re: HIPAA Notice of Privacy Practices.)*

_______ _______ I, the client/client's guardian, consent to participation in indoor and outdoor physical activities as a part of my therapeutic time at Daybreak Therapy Solutions, including but not limited to throwing/catching footballs/baseballs, running, jogging, stretching, and other light exercise. I understand that I am responsible for notifying the staff at Daybreak Therapy Solutions about any pertinent physical or medical conditions that would impede my ability to participate or increase risk of injury. I understand that the staff at Daybreak Therapy Solutions makes every effort to ensure the safety of all participants but that unexpected situations can arise. I hereby release and waive Daybreak Therapy Solutions LLC and all staff, owners, and clinicians affiliated with the aforementioned from liability for any and all loss, damage, injuries, claims, demands, lawsuits, expenses, and any other liability of any kind, of or to me or any other person, directly or indirectly arising out of or in connection with my participation in any activity.

_______ _______ I, the client/client's guardian, understand that Daybreak Therapy Solutions LLC strives to provide healing to children and families by utilizing healthy attachment behavior, which includes touch. Touch is a normal, healthy part of all parent-child interactions and therapists here will strive to model the healthy uses of touch in building safe relationships with children while providing both structure and nurture along developmentally appropriate continuums. Several of the intervention models we practice here, including play therapy, Theraplay, Trauma Play, and TBRI, as well as the SOOTHE co-regulation strategies that we offer to caregivers, place a high value on the importance of healthy touch experiences for children in fostering connections with others, building empathy, enhancing playfulness and even in releasing neurochemicals that help to calm the child. We also value the sharing of healthy touch between parents and children and will model touch and support parents in providing healthy touch experiences to their children. While we are careful in how we implement touch-based treatments with children who have survived abuse or trauma, we believe that these children need safe, healthy touch experiences. Healthy touches you might see here at Daybreak include high fives, fist bumps, elbow bumps, handshakes, shoulder pats, and hugs.

For more information regarding our philosophy of touch, please refer to these resources: Courtney, J. A., & Nolan, R. D. (Eds.). (2017). Touch in Child Counseling and Play Therapy: an ethical and clinical guide. NY, NY: Routledge. Field, T.M. The therapeutic effect of touch. In G. Brannigan & M. Merrens (Eds.), The undaunted psychologists: Adventures in research (pp. 3-12). New York: McGraw Hill, Inc., 1993. Panksepp, J. The long-term consequences of infant emotions: prescriptions for the twenty-first century. Infant Mental Health Journal. Vol. 22(1-2) Jan-Apr, 2001. The Paper on Touch, published by the Association for Play Therapy and available at www.a4pt.org. The Healthy Touch video produced by the Texas Christian University Child Development Center The Statement About the Use of Touch in Theraplay Treatment, available at http://www.theraplay.org/index.php/touch-statement

_______ _______ I, the client/client's guardian, understand that in addition to the rights and responsibilities outlined in this consent form, I also hold the following client rights:

Equal Treatment

- The right to be treated without regard to race, religion, gender, sex, age, marital status, national origin, sexual orientation, gender identity or expression, developmental disabilities, or mental or physical handicap.
- The right to have access to translated materials or translators who can assist me if English is not my first language.
- The right to be provided treatment and services in an environment free of abuse, neglect, financial exploitation, humiliation, or any other human rights violation.
- The right to access self-help, advocacy, and legal services.
- The right to be protected from coercion.

Confidentiality and Privacy

- The right to privacy, security, and confidentiality of my identity, diagnosis, prognosis, and treatment.
- The right to have the entire staff keep my identity, diagnosis, prognosis, and treatment confidential.
- The right to be treated respectfully regarding my privacy.
- The right to understand how my Protected Health Information (PHI) is disclosed for purposes of treatment, payment, and health care operations.
- The right to the confidentiality of my medical records and source of payment for services.
- The right to require my consent for the use of tape recordings, videotapes, and/or photographs of you, and to be informed of their purpose and how they will be used.
- The right to provide or refuse authorization for family members or others to participate in my treatment or for the release of confidential information to family members or others.
- The right to access my medical records in compliance with applicable state and federal laws in sufficient time to make decisions regarding my care.

Treatment with Dignity

- The right to be treated with respect for my personal dignity.
- The right to receive safe and considerate treatment in the least restrictive environment.
- The right to refuse to participate in any research study without losing treatment services.
- The right to exercise my rights as a client of Daybreak Therapy Solutions, LLC / Melissa Sepeda, LCSW-BACS without fear of adverse consequences.

Service by Qualified Staff

- The right to have qualified, competent staff supervise and provide me with services.
- The right to be provided, upon request, information about the credentials, training, professional experience, and

specialization of my providers and their supervisors.
- The right to obtain the Code of Ethics, upon request.

Information about Treatment and Medications

- The right to be informed of interventions, services, treatment, and medication in a language I understand.
- The right to have the opportunity to ask questions about my rights.
- The right to be given the name, professional qualifications, and position of the staff member responsible for my care, as well as their supervisor's name.
- The right to be informed in advance if there is a change in my primary therapist.
- The right to be informed of what to expect when I receive treatment.
- The right to be told about the risks, benefits, and side effects of any proposed medications, interventions, services, or treatment.
- The right to refuse any treatment or medication to the extent permitted by law, and to be informed of the likely results of my refusal.
- The right to be informed in advance if I am to be transferred to a different treatment program, and the right to be given an explanation for these changes.
- The right to receive a copy of the patient brochure, which contains program rules, services provided, clients' rights, and other important information.
- The right to be informed about the use of a seclusion or restraint for an emergency situation only and when less restrictive measures have been attempted and failed.
- The right to be informed about, and to participate in, decisions regarding my treatment and services and to receive the information necessary for you to make informed decisions, including:
    - My current diagnosis
    - The limitations of confidentiality
    - Projected discharge date and plan
    - Potential risks if treatment is not provided
    - Ongoing review of my treatment goals, and mutually agreed upon adjustments of the treatment or service plan
- The right to object to any changes in treatment, services, or personnel, and the right to a clear and written explanation if such an objection cannot be accommodated.
- The right to be referred to an alternate service, program, or treatment setting if I would be better served at a different level of care.
- The right to screening for pain management, with a referral to my health care provider if appropriate.

Participation in Your Treatment Plan

- The right to participate in the development of my treatment plan and to receive treatment accordingly.
- The right to request a change of provider, clinician, or service, and if the request is denied, the right to receive a written explanation.
- The right to be informed of the cost of services, the source of reimbursement, and any limitations placed on my treatment.
- The right to have my treatment plan reviewed and updated periodically.
- The right to review my medical records with my primary therapist and/or to request a review of my treatment plan by another staff member (at no cost) or by an outside consultant (at my expense).
- The right to be informed of relevant alternative medications, treatment, services, or interventions when appropriate.
- The right to participate in planning aftercare activities and referrals to other community services such as spiritual services that may help in recovery or improvement.
- The right to provide feedback on program policies and services through satisfaction surveys.
- The right to be provided, upon request, information regarding charges billed to and payments made by an insurance company on my behalf.
- The right to withdraw, at any time, my agreement to an element, or to all elements, in a behavioral management agreement or plan, and to be advised of the potential risk and impact on my treatment process.

_______ _______ I, the client/client's guardian, give consent for Daybreak Therapy Solutions to communicate with me through email and/or text messaging. I understand that emails and text messages will be utilized for scheduling concerns, quick questions, and referrals, not as a substitute for actual therapeutic engagement. I understand that although Daybreak Therapy Solutions will take every precaution to protect my information, there is an inherent risk in using these technologies and that my protected health information may be intercepted by an unauthorized third party. ***I also understand that my provider may not always be immediately available and that I cannot use text messaging in a crisis. It is still my responsibility to call 911 or the Our Lady of the Lake COPE Team at 225-765-1050 if I am in crisis.***

_______ _______ I, the client/client's guardian, acknowledge that I have received a copy of the **HIPAA Notice of Privacy Practices** outlined below for Daybreak Therapy Solutions, LLC and have read and understand it in its entirety:

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" or "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

HIPAA Notice of Privacy Practices Continued

Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- To treat you-we can use your health information and share it with other professionals who are treating you within our practice, including supervisors. We also share information with your other providers, such as your PCP, to coordinate care when applicable and with separate written consent.
- To run our practice-we can use and share your health information to run our practice, improve your care, and contact you when necessary.
- To bill for your services-we can use and share your health information to bill and get payment from health plans or other entities.
- To coordinate with select people you have identified-we can share certain PHI with those individuals that you have written separate authorizations to release and obtain information for that you deem integral to your care.

What other instances would we disclose PHI? In some situations, we are obligated and mandated to release select PHI. These situations include:

- When the client expresses suicidal, homicidal, or self-harming ideation or there is reasonable evidence to support the concern that the client is a threat or harm to themselves or others.
- As legally mandated reporters, we are required to report any disclosures or reasonable suspicions of abuse or neglect of minor children, dependent adults, or elderly persons (60 or older).
- When a court order or subpoena is received directing the disclosure of information, we are legally mandated to comply.
- When therapy is court-ordered, some PHI related to treatment may be mandated to be released to specific parties.

Your Rights to Confidentiality and Privacy

- The right to privacy, security, and confidentiality of your identity, diagnosis, prognosis, and treatment.
- The right to have the entire staff keep your identity, diagnosis, prognosis, and treatment confidential.
- The right to be treated respectfully regarding your privacy.
- The right to understand how your Protected Health Information (PHI) is disclosed for purposes of treatment, payment, and healthcare options.
- The right to the confidentiality of your medical records and source of payment for services.
- The right to require your consent for the use of tape recordings, videotapes, and/or photographs of you, and to be informed of their purpose and how they will be used.
- The right to provide or refuse authorization for family members or others to participate in your treatment or for the release of confidential information to family members or others.
- The right to access your medical records in compliance with applicable state and federal laws in sufficient time to make decisions regarding your care.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Questions or Complaints

You may contact us at any time regarding questions about your PHI and privacy. You may also request a copy of this Notice at any time. If you have a complaint, you may contact our HIPAA Privacy Officer, Jeremiah Kraus, at jkraus@daybreaktherapysolutions.com.

_______ _______ ***Media Use Informed Consent:*** I, the client/client's guardian, give consent for Daybreak Therapy Solutions to take and using my child's image(s) and likeness(es) for educational, training, advertising, and marketing purposes via their website, social media outlets, and in training materials. I understand that there is no compensation agreement for the use of these image(s). I understand that I am authorizing the release of select PHI (Protected Health Information) via these image(s) (i.e., my child's face, voice). I understand that this participation is *voluntary* and have been sufficiently informed of my rights and terms of this agreement: Your child's identifying demographic information (full name, age, DOB, etc.) will NOT be shared on public platforms. Their diagnoses or treatment goals will NOT be shared on public platforms. Your child will be asked for their permission for the photo/video beforehand. Nothing will be taken without your child agreeing beforehand. You may revoke this consent at any point via written amendment to this form. Your treatment services with Daybreak Therapy Solutions are no way affected by or contingent upon your consent or denial of media use. If I do *not* consent to the above media use consent, I will leave the signature spots blank.

Please continue to the next page for final signatures.

Pediatric Informed Consent to Treatment

My signature below means that I understand and agree with all of the points listed in these pages and I have no important questions or concerns that we have not discussed.

Signature of Parent/Guardian #1 | Date

Signature of Parent/Guardian #2 | Date

I, the therapist, have discussed the issues above with the client. My observations of this client's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Signature of Therapist | Date

Signature of Clinical Director Josie-Grace Bridges, LCSW | Date

Signature of Owner/CEO Melissa Sepeda, LCSW-BACS | Date