



**Sundance Center of Arlington
Child & Adolescent Outpatient Program**

7100 US-287 Hwy
Arlington, TX 76001

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www.sunbhc.com

Sundance Center of Arlington Outpatient Staff

Your Sundance Team:

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817.763.5665

Psychiatrist
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Nursing Staff:
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817.583.8130

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Youth Two
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Education Coordinator
Sundance Center Arlington
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817.583.8066

Adolescent
Brandi Rhoden, LMSW
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817.583.8132

Mental Health Techs:

Michael Jones, Lead MHT

Erica Boston, MHT

Admission Checklist

The following is a list of items to bring for admission:

1. Lunch, 2 snacks and an **unopened** drink in a **1-gallon Ziploc bag** with his or her name on it (microwaves will be available)
2. **Legal documents** showing a custody arrangement if you are divorced, legal guardian, power of attorney, or adoptive parent
3. Proof of insurance, if applicable
4. Legal form of identification (of the guardian)

Individual Family Therapy

While your child is in the PHP level of care, **parents/legal guardians will be required to attend** family therapy sessions on a weekly basis. The family therapy sessions are typically held during the center's operating hours between 8 AM – 5 PM. Your child's therapist will contact you to schedule an appointment.

Home Sheets

An important aspect to the Sundance Center of Arlington's program is the Home Sheet. These reports are an excellent communication tool for your child's treatment team (physician, therapist, nurse etc.). We ask that the parent/legal guardian completes one each evening for the patient to turn in at "check-in" the next morning. It is important to be detailed and honest on these reports so that we may assist you in the best way possible. One will be sent home with your child every day.

Treatment Program Rules

***No exchanging of personal information such as phone number, address, email, last names, school attended, friending on Facebook, Instagram, Snap Chat or other social media sites etc. Do not contact or visit peers outside of treatment facility.**

1. All patients must bring a nutritious lunch daily, along with 2 snacks. Patients may not share or trade food. Parents/legal guardians will be notified if patient does not bring lunch. **Sundance does not provide lunch or snacks.**
2. Keep hands, feet and objects to yourself at all times. No physical or verbal aggression toward self, staff, or peers. No threats, profanity, or bullying.
3. Patients must remain in the building at all times, unless permission is granted by a staff member. Leaving the building without permission will result in police, parent/legal guardian, and probation officer, (if applicable), notification.
4. Patients must remain in group sessions, unless permission is granted by a staff member. Patients may request a Personal Time Out (PTO) or to use the restroom etc. Staff has the right to deny patient a PTO if they are suspected of using PTO's manipulatively or as a way to get out of group.
5. Be respectful of all property. No destruction of property. **You may be financially responsible for damage incurred.**
6. Maintain personal space at all times. No hugging, touching, kissing, etc.
7. No lending, giving, or borrowing of items. This includes, but is not limited to, clothing, food, personal belongings etc.
8. **Daily attendance is mandatory.** Exceptions are made with a doctor's note or letter from the court.
9. No smoking or gum chewing on the premises. **Chewing gum will result in loss of points and/or privileges.**
10. **Patients may only drive themselves to Sundance with permission from the treatment team.** All keys, wallets and cell phones will be turned into the designated staff at the beginning of the day and will be returned at dismissal. Patients who are not compliant with rules or do not return home from treatment on time, will receive one warning phone call home and then will have driving privileges revoked.
11. **Do not bring contraband items** – cigarettes, lighters, illegal drugs, over-the-counter drugs, prescription drugs, weapons, alcohol, gum, sharp objects, cell phones, iPad, cameras, tablets, hand held games, make-up, purses, bags, jewelry, I-pods, toys, or excessive amounts of money (greater than \$5.00).
12. **If a cell phone or any other contraband items are brought into the facility the following actions will be taken;** The first offence will result in a verbal warning and loss of privileges, the second offence will result in a phone call home and loss of privileges, a third time will result in confiscation of the item until time of discharge.
***If brought, these items may be held or disposed of, depending on the item, by staff until the patient is discharged from the program. At that time, the item will be returned to parents/legal guardians. *Sundance Behavioral Healthcare is not responsible for loss or theft of items brought into facility.**
13. **No talking during transitions.** (i.e. going to and from gym or to and from vans.)
*Inability to follow program rules may result in possible transfer to an alternate level of care, or DISCHARGE.

Dress Code

The appropriateness of clothing will be determined by staff members. There will be consequences for patients who are not compliant with the dress code. If necessary, parents/legal guardians may be called to bring appropriate clothing to Sundance for their child. Coats and jackets will be collected upon arrival and returned upon dismissal from the program. Any clothing articles with a hood or zipper may not be worn in the group rooms. Patients may wear pullover sweaters or sweatshirts during the day. **Please abide by the dress code and bring only yourself, your lunch, and your Home Sheet to treatment each day.**

The following items are **NOT** permitted:

1. NO cell phones, purses, make-up bags, backpacks, combs, brushes, or wallets
2. NO short shorts or skirts (no shorter than 4 inches above the knee)
3. Only ONE bracelet on each arm is permitted
4. NO high heels or boots. Tennis shoes is the best footwear.
5. NO clothing depicting sex, violence, drugs, alcohol, death, demonic themes, concert/band t-shirts, and clothing reflecting gang affiliation
6. NO facial or tongue piercings or visible tattoos
7. NO type of head covering (i.e. hats, bandanas, hoods, sweat bands)
8. NO belts with large metal buckles or metal studs
9. NO short, tight, see-through, low cut, or otherwise revealing garments
10. NO sleeveless shirts or tank tops – clothing must cover the crown of the shoulder and the entire torso at all times
11. NO oversized clothing or pants/ shorts that are sagging, ripped, or layering shorts and pants (Only one pair of shorts may be worn at a time), Pajama pants
12. NO sunglasses and non-prescription color contact lenses

Safety Plan

I HAVE RECEIVED AN EXPLANATION OF MY RESPONSIBILITIES AND AGREE TO COMPLY AS PART OF THE SAFETY PLAN FOR MY CHILD WHILE MY CHILD IS IN TREATMENT AT SUNDANCE BEHAVIORAL HEALTHCARE.

Secure all prescribed and over the counter medications (Tylenol, cough syrup, aspirin, etc.) and administer them to your child. Observe your child swallowing the medicine and remain with your child for a few minutes afterwards to prevent “cheeking” and/or hoarding of medications.

Regardless of how guns are stored, type of guns, or number of guns, storing guns in the home is associated with increased risk of suicide and homicide attempts. If a gun is used, suicide attempts are 78-90% more likely to be fatal. We strongly recommend guns be stored outside the home.

Do you currently have guns stored in the home?

- Yes No

How are they stored? _____

How will you secure the weapons while your child is in treatment? _____

Remove and/or secure all potentially harmful or dangerous objects from the home, car, etc. as these items may be a means of committing suicide impulsively. **This includes guns, ropes, razors, scissors, sharp knives, matches/lighters, large amounts of pills, liquid bleach products or any other items that you feel might be unsafe.** Do not allow the use of illegal drugs and alcohol.

Follow your instincts, if you feel your child may act impulsively and attempt suicide make sure someone is with him/her at all times and take your child to the nearest emergency room.

Examine your child regularly for self-harm behaviors. If you feel that your child cannot remain safe take your child to the nearest emergency room for evaluation.

Take comments of suicide threats seriously. Report these to the treatment center staff as soon as possible.

Call 9-1-1 immediately if you suspect your child took an overdose of medication.

Attendance Policy

Daily attendance is mandatory due to insurance procedures as well as therapeutic success.
(4-6 week length of stay)

Please initial:

	I.	Please RESCHEDULE any planned doctor or dental appointments outside of program hours. Please contact the patient's therapist with any questions or concerns. During School Year : 9AM- 3PM. During the Summer Program : 9AM-1:30PM.
	II.	<u>Family Vacations</u> are NOT considered excused absences by insurance companies
	III.	<u>Illness</u> a. Unless your child is running a temperature in excess of 100°F , please have them attend treatment. Our nursing staff will evaluate your child to determine if a doctor's appointment is necessary. b. If your child is absent for more than 2 days , a physician's note is required for insurance.
	IV.	<u>Holidays and Inclement Weather</u> c. Sundance is closed for 7 holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, The Day After Thanksgiving, and Christmas Day. d. In case of inclement weather, Sundance follows Arlington ISD's inclement weather closings. You may also verify closure status by calling the main hospital number at 817.583.8080.

Subpoena Policy Information

Our purpose in working with your family is to help you and your child reach a higher level of functioning and increase your level of happiness and success. We are concerned about the wellbeing of your family.

Our purpose is not to become involved in current or future legal battles that may develop in your family. It is our hope that this will not occur. If you do have legal conflict in the future, please be aware that it could be detrimental to your child to involve confidential treatment information. This may prevent your child from feeling he/she can trust mental health professionals in the future. Also, please be informed that only mental health professionals appointed by the court can ethically make custody recommendations. It is not appropriate for Sundance staff to do so, as we are involved in treatment, not court-ordered evaluation. If we are concerned about the safety of your child, we will report all concerns to the proper authorities.

After reading this, understand that if you do subpoena any health professional associated with treatment of your child at this facility with less than two weeks' notice, you will be assessed a fee of \$2,000.00 per professional subpoenaed. If you or your attorney believes our testimony is necessary, you can avoid this fee by calling and discussing this with us and providing a subpoena with adequate notice. If an arrangement is made for one of our qualified staff members to testify, you will be subject to that mental health professional's hourly rate for legal testimony.

We want the best for you and your family.

Behavioral Intervention Information

Sundance Behavioral Healthcare is committed to protecting children's rights. At the same time Sundance Behavioral Healthcare is committed to protecting children from hurting themselves or others while they are at our facility. The following is a step-by-step explanation of interventions we use. All of these interventions have been approved by our Medical Staff, Board of Directors, and only those staff members who are **trained, competent, and privileged** are allowed to conduct these interventions:

1. Redirecting the child from an inappropriate behavior to an appropriate behavior.
2. Conducting a 1:1 discussion with the child.
3. Asking the child to take a 15-minute personal time-out in a quiet area.
4. Providing environmental situations which will help the child to calm themselves (i.e. music, a walk with staff, punching a pillow, etc.).
5. Performing a physical therapeutic hold (up to 30 minutes at a time) to help the child regain control of their behavior.

Restraints and seclusions are utilized at Sundance Outpatient Centers when there is an immanent safety risk. ALL staff members are trained in Crisis Prevention Intervention (CPI).

Every intervention that Sundance Behavioral Healthcare provides is done in a manner that is dignified, respectful of the child, and most of all- safe. Please contact Sundance Behavioral Healthcare at 817.583.8038 if you have any questions regarding Behavioral Interventions.

Admissions and Treatment Information and Guidelines

Consent for Admission

The undersigned acknowledges that no guarantee or assurance has been made to them, or the patient, regarding the results of the services provided for the patient, including, but not limited to, therapy, treatment, tests or procedures, while admitted to Sundance Behavioral Healthcare.

The undersigned acknowledges that Sundance Behavioral Healthcare is a teaching facility and that professional students may have patient contact and access to the patient's medical records. These students are supervised by a licensed professional and are required to meet the Center's confidentiality standards.

The undersigned consents to Sundance Behavioral Healthcare taking photographs for identification purposes. The photographs may remain permanently in the patient's medical record.

The undersigned authorizes Sundance Behavioral Healthcare to search the personal belongings of the patient upon arrival daily. Should any contraband items be found, it is understood that they will be retained in a safe place and returned to the parent/legal guardian upon discharge unless otherwise indicated by the attending physician.

Sundance Behavioral Healthcare assumes no liability for loss or damage to vehicles parked on Center premises. Patients are encouraged not to leave personal property or vehicles on the premises.

The undersigned realizes that Sundance Behavioral Healthcare retains no liability for the loss or damage of personal property and/or money. Any personal articles left behind at the time of discharge will be disposed of after 15 days.

Consent for Treatment

The undersigned gives Sundance Behavioral Healthcare, its staff, and attending physicians' permission to render to the patient all customary care, treatment, therapy, tests and procedures considered advisable, including emergency treatment and transportation to another facility if necessary. Consent is also given for any medical treatment, diagnostic procedure, recreational activities and therapy, and other treatment ordered by Sundance Behavioral Healthcare and/or attending physicians including but not limited to services provided by other Healthcare Professionals to the patient.

Admissions and Treatment Information and Guidelines (Continued)

The undersigned agrees that Sundance Behavioral Healthcare will not be responsible for the safety or care of the patient should the patient leave the premises and will indemnify Sundance Behavioral Healthcare for any loss or injury which may occur as a result of leaving Against Medical Advice (AMA).

The undersigned affirms he/she agrees that all medications must be administered by an adult while at home or by a licensed nurse while he/she is at Sundance Behavioral Healthcare during program hours.

Responsibility for Destruction of Property

The undersigned agrees that patients are responsible for any damage they cause to Sundance Behavioral Healthcare property, or property of others which may be located on center premises. The undersigned understands that they must accept liability for, and reimburse Sundance Behavioral Healthcare or other owner of the property for, any property that they destroy or damage.

Consent to Acknowledge Your Presence

The undersigned acknowledges that Sundance Behavioral Healthcare will not release any information unless we have a release of authorization to do so. The undersigned hereby gives consent for Sundance Behavioral Healthcare to inform the patient's physician and/or referral sources of patient's admission to, and progress at the center.

Acknowledge Receipt of Patient Rights and Grievance Policy

The undersigned acknowledges that a copy of the patient rights and grievance policy has been given to them, that the rights have been explained, and that they understand these rights.

Policy Regarding the Use of Seclusion and Restraint

It is the belief of Sundance Behavioral Healthcare that the usage of least restrictive behavioral management techniques is in the best interest of your child. However, we do authorize the use of seclusion or restraint techniques when imminent risk of injury exists. We may administer emergency medications to assist your child in regaining control of his/her behavior. Sundance Behavioral Healthcare will notify the parent/legal guardian if emergency medication is required during the day. The undersigned acknowledges that a copy of the behavioral interventions information has been given to them, and that it is understood.

Applicability to Other Providers

The undersigned agrees that in the event other healthcare professional providers, including but not limited to other hospital(s), furnish services to the patient while at Sundance Behavioral Healthcare, the consent(s), assignment(s), guarantee(s), and release(s) herein above set out shall apply to other such providers and services.

Patient Name

Parent/Legal Guardian Signature

Staff/Witness Signature

Date

Date

Consent to Release/Obtain Information Form

Please complete in **BLACK** ink.

The type of information released and obtained includes information relating to any physical, psychiatric, or drug/alcohol related condition. Sundance Behavioral Healthcare may obtain or release information regarding notification of admission, information on treatment plans, discharge/aftercare plans, physical exam, and results of urinalysis, psychiatric evaluations, psychological testing, treatment summary, progress, medical/psychiatric history, and educational transcripts. The type of information authorized for disclosure includes, but may not be limited to, that which is listed above. By signature below, I hereby authorize Sundance Behavioral Healthcare to release and obtain information to and from the following individuals via verbal and/or written communication, facsimile and mail:

Healthcare Professionals

Psychiatrist Name	Phone Number	Initial
Therapist Name	Phone Number	Initial
Physician Name	Phone Number	Initial

School

Name of School	Name of School District	Phone Number	Initial
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Probation Officer

Name of Probation Officer	Phone Number	Initial
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CPS/Foster Care

Name of CPS Worker	Phone Number	Initial	
Name of Foster Care Representative	Foster Care Agency	Phone Number	Initial

Family Members/Emergency Contacts

Name of Family Member	Relationship to Patient	Phone Number	Initial
Name of Family Member	Relationship to Patient	Phone Number	Initial
Name of Family Member	Relationship to Patient	Phone Number	Initial
Name of Emergency Contact	Relationship to Patient	Phone Number	Initial

Other

Other Contact Name	Relationship to Patient	Phone Number	Initial
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The consents provided on this form are subject to revocation or change at any time except to the extent that Sundance Behavioral Healthcare has acted in reliance thereon. If not previously revoked, the consents will terminate sixty days (60) after the patient's discharge.

***Notice to recipients of information:** *The information disclosed to you was taken from records of which the confidentiality is protected by Federal Law. Federal Law also protects the confidentiality of alcohol and drug abuse patient records. Federal Regulations prevent you from making any further disclosure of forwarded information without the specific written consent from the person to which it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose*

Patient Name

Parent/Legal Guardian Signature

Date

Staff/Witness Signature

Date

Overview of Program

Patient:	Admit Date:
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PHP Overview (Partial Hospitalization Program)	IOP Program (Intensive Outpatient Program)
<ul style="list-style-type: none"> • Attendance is Mandatory • Process and skills approach to daily group therapy • Academic Classes • Individual Family Therapy (approx. weekly) • Visits with psychiatrist on an individual basis • Multiple means of communication with the Clinical Treatment Team (Nurses, Therapists etc.) • Management and stabilization of medications • Case management by the Clinical Treatment Team • Complimentary Transportation • Complimentary Before/Aftercare <p>Regular Hours: (Before-care: 8AM-9:00AM; Aftercare 3PM-5:00PM) Summer/Early Release Hours: (before care: 8AM-9Am; Aftercare 1:30PM-4:30PM)</p>	<ul style="list-style-type: none"> • Attendance is Mandatory • Process and skills approach to daily group therapy • Academic Classes • Phone consultation with therapist • Visits with psychiatrist on an individual basis • Multiple means of communication with the Clinical Treatment Team (Nurses, Therapists etc.) • Management and stabilization of medications • Case management by the Clinical Treatment Team • Complimentary Transportation • Complimentary Before/Aftercare <p>Regular Hours: (Before-care: 8AM-9:00AM; Aftercare 3PM-5:00PM) Summer/Early Release Hours: (before care: 8AM-9Am; Aftercare 1:30PM-4:30PM)</p>

I, _____ understand the requirements of the program and agree to abide by the requirements. Any activity to the contrary will result in a review of the circumstances and could result in my child's immediate discharge from the Sundance Behavioral Healthcare Program.

Physician Fees Non-Inclusive Insurance Contract

Your insurance carrier's contract with Sundance Behavioral Healthcare is non-inclusive. Your physician (psychiatrist) will bill separately for each visit with the patient while in treatment at Sundance. In addition to receiving a bill for services from Sundance, you will also be receiving a separate bill from the physician's office. These services are handled directly with the physician's office staff. If you have questions regarding billing, the contact phone numbers are listed below.

Dr. Indukuri's billing is handled by his private office. You can reach his office manager at 817.222.9907 with any billing questions and to set up payment arrangements.

Dr. Sunkara's billing is handled by his private office. You can reach his office manager at 817.715.9756 with any billing questions and to set up payment arrangements.

Patient Rights

Patients have to following rights during their treatment at Sundance Center of Arlington:

- To freedom from abuse, neglect or exploitation
- To appropriate treatment in the least restrictive setting available that meets your needs
- To a humane treatment environment that provides reasonable protection from harm and appropriate privacy for your personal needs
- NOT to receive unnecessary or excessive medication
- To be treated with dignity and respect
- To accept or refuse treatment after receiving the explanation
- To meet with staff to review and update your treatment plan on a regular basis
- To be informed about the program's rules and regulations before you are admitted
- If you agree to treatment or medication, the right to change your mind at any time (unless specifically restricted by law)
- To have information about you kept private and to be told when the information can be released without your permission
- To a treatment plan designed to meet your needs and the right to participate in developing that plan
- To refuse to participate in research without affecting your care
- Not to be restrained or locked in a room by yourself unless you are a danger to yourself or others
- To be told in advance of all estimated charges and limitations on the length of services the facility is aware of
- To communicate with people outside the facility (with the exemption of patients), to have visitors, make phone calls, and to receive and send sealed mail. This right may be restricted on an individual basis by your doctor if it is necessary for your treatment or security, but even then, you may contact an attorney or if you are a chemical dependency patient, the Texas Commission on Alcohol and Drug Abuse at any reasonable time. Patients in the PHP/IOP program are requested to exercise these rights during non-program hours.
- To make a complaint and receive fair response from the facility within a reasonable amount of time
- To leave the facility within 4 hours of requesting release unless a physician determines that you pose a threat of harm to yourself or others. (Patients under the age of 18 may not make the decision to leave treatment without parental/ legal guardian consent.)
- To receive an explanation of your treatment or your rights if you have questions while you are in treatment
- The right to receive a copy of these rights before you are admitted
- You have the right to make a complaint to the Sundance Center of Arlington Patient Advocate, Lance Parker at 817.583.8080.
- To have your rights explained to you in simple terms, in a way that you can understand, within 24 hours of your admission
- The right for the following information before admission:
 - The condition to be treated
 - The proposed treatment
 - The probable health and mental health consequences of refusing treatment
 - Other treatments that are available and which ones, if any, might be appropriate for you
 - The risks, benefits, and side effects of all proposed treatment and medications

Grievance Policy

You may file a grievance about any violation of your rights or the rules regulating this facility to the following:

Misty R. England: Director of Outpatient Services (817.583.8083 / misty.english@sunbhc.com)

Lance Parker: Patient Advocate (817.583.8080 / lance.parker@sunbhc.com)

The Joint Commission (800.994.6610)

You may request writing materials, postage, or access a telephone for the purpose of filing a grievance

You may submit your grievance in writing and receive help in writing if you are unable to read or write

You will receive a copy of the grievance procedure with an explanation in clear, simple terms that you can understand within 24 hours of admission

Authorization to Participate in Outside Activities/Outings and Outside Speaker Consent Form

Outside Activities/Outings

Occasionally, Treatment Groups will participate in outside activities or outings during their recreational therapy time (pending eligible level) such as to the local park, Botanical Gardens, bowling, local museum, etc. You will be notified of scheduled activities requiring admission fees, special costs, etc.

Authorization to participate and permission to attend on behalf of my child, is given for representatives of the Sundance to:

Transport my child by van transportation for the purpose of scheduled activities, in which all van rules apply.

Transport my child in case of emergency to: _____ (Preferred Hospital Name), or the **nearest hospital**.

I consent and authorize representatives of Sundance Behavioral Healthcare to authorize (in my absence) emergency medical treatment at the above-designated hospital. I authorize emergency medical treatment at Cooks Children's Medical Center in the event that they are closer than my previously designated medical treatment facility.

Child's Physician: _____

In case of an emergency, Sundance Behavioral Healthcare has permission to contact:

Emergency Contact Name

Contact Number

Relationship

Outside Speaker Consent

Sundance may offer the opportunity for your child to participate in a group in which community professionals come in to work with the children. These community members will be individuals who are highly trained in their area of expertise. For example, we may have a school teacher, nutritionist, therapist, probation officer, or other professional speak to patients. The undersigned gives their child, _____, permission to participate in groups with outside speakers. The undersigned also understands that they may rescind this permission at any time by speaking with their child's therapist.

Transportation rules and procedures

- The van driver will plan out the route and contact you to provide you with an approximate drop-off and pick-up time
- The pick-up and drop-off time are approximate and may vary **on a daily basis**
- The van driver will wait **approximately 5 minutes** at each pick-up location.
- There can be up to 14 patients on each van
- There will be patients of all ages on the van, ranging from 5 to 18 years of age
- The driver is the only adult on the van, which means no clinical staff will be on the van
- **Patients may be suspended for up to three days (or expelled if necessary) from the van for inappropriate language and/or behavior.** Based on the incident, the van driver may bring the child back to Sundance Behavioral Healthcare and the parent/legal guardian will be contacted for an emergency family session.
- The patient can only be transported to and from the PICKUP STOP (see next page) location. Your child may not go home with another patient, even if an adult is driving

The parent/legal guardian **must call the Transportation Driver**, if there are any changes to the established transportation arrangements. It is imperative that you communicate any transportation changes to the driver directly. **Transportation arrangements MUST be made by 2:15PM during the school year and 12:45PM during the summer.** Changes in transportation arrangements **WILL NOT BE ACCEPTED** after this time.

Before/Aftercare rules and procedures

- There will be patients of all ages in before/aftercare, ranging from 5 to 18 years of age
- A Mental Health Technician (MHT) will supervise before/aftercare. Clinical staff are not available during this time.
- Patients may be suspended for up to three days (or expelled if necessary) from before/aftercare for inappropriate language and/or behavior. Based on the incident, the MHTs may call the parent(s)/legal guardian(s) or authorized representative(s) to pick the child up.
- Patients will only be released to the parent(s)/ legal guardians(s) or authorized representative(s) listed, identified in the Consent to Release/Obtain Information Form or Face Sheet completed at the time of admission.
- Patients may **NOT** go home with another patient, even if an adult is driving.

Transportation Authorization and Acknowledgement

Before/Aftercare Authorization and Acknowledgement Form

- Request Transportation Service
- Request Before/Aftercare

Patient Name	Start Date	
Parent(s)/Legal Guardian(s) Name(s)		
Address	City	Zip Code
Cell Phone	Work Phone	Home Phone

Regular Hours

Before Care Starts at 8:00 a.m.
After Care Hours: 3:00 p.m. - 5:00 p.m.
Transportation Vans Leave at 3:00 p.m.

Summer/Early Release Hours

Before Care Starts at 8:00 a.m.
After Care Hours: 1:30 p.m. – 4:30 p.m.
Transportation Vans Leave at 1:30 p.m.

Parents/legal guardians will need to bring and pick up their child to Sundance on the day of admission.

My child may be dropped off or picked up by:

Authorized Representative	Contact Number	Relationship	Initial
Authorized Representative	Contact Number	Relationship	Initial
Authorized Representative	Contact Number	Relationship	Initial

Please **CHECK** Location for pick up and drop off and indicate location below:

Stop #	Location	Address
1	Quick Trip i20-Wichita	6549 Wichita St, Forest Hill, TX 76119
2	Chase Bank 820/Ramey	6040 Ramey Avenue, Fort worth, TX 76112
3	El Rio Grande 35-Berry St	3037 South Fwy, Fort Worth, TX 76104
4	Shell i20-Mccart Ave	2526 SW Loop 820, Fort Worth, TX 76115
5	Circle K i20-Winscott	8000 Winscott Rd, Fort Worth, TX 76126
6	Seven Eleven 35-Alsbury(Burleson)	898 NE Alsbury @ I-68W Sr, Burleson, TX 76028
7	Exxon 35-Sycamore School Rd	101 Sycamore School Rd, Fort Worth, TX 7613
8	Fiesta 820-Meadowbrook	324 Meadowbrook Dr, Fort Worth, TX 76112
9	QT 287- Debbie Lane	1601 FM157, Mansfield, TX 76063
10	Wal-Mart 20/Little Rd	4800 US 287 Highway, Arlington, TX 76017
11	Walmart Matlock-Sublet	735 W Sublet Rd, Arlington, TX 76017
12	Quick Trip i20-Collins	4201 S Collins St, Arlington, TX 76018
13	Valero Randal Mill/Collins	936 N Collins Arlington, TX 76011
14	Valero Collins/Arkansas	4600 S. Collins Arlington, TX 76018
15	Valero Cooper/Randal Mill	652 W. Randal Mill Rd. Arlington, TX 76011
16	Exxon 360-Mayfield	3051 E Mayfield Rd, Grand Prairie, TX 75052
17	Waffle House i20-Great Southwest Pkwy	2610 West, Grand Prairie, TX 75052
18	Kohls i20/Carrier	3865 S Carrier Pkwy, Grand Prairie, TX 75052
19	Taco Cabana 360-Pioneer West	2531 E Pioneer Pkwy, Arlington, TX 76010
20	E-Z Mart New York/Arbrook	1901 E Arbrook Blvd Arlington, TX 76014
21	Loves 287/67(Midlothian)	1501 W Hwy 287, Midlothian, TX 76065

Pick-Up Only

Drop-Off Only

Both

Pick Up Location: _____

Drop Off Location: _____

*** LOCATION AND TIMESVARY**

***Van Drivers will contact you.**

Educational Program and Procedures

Sundance Center of Arlington Education Program

Description of Services:

The Sundance Center of Arlington provides instruction for children grades K-12 in the core subject areas of Math, Reading/English, Science, and History during your child's treatment stay. Our school curriculum is based on State assessments to help your child with mastery in these subject areas. At Sundance Behavioral Healthcare, we aim to provide an educational climate in which patients can develop mentally, emotionally, and socially as they complete their treatment goals. As a hospital the primary goal is providing treatment for your child. However, we understand that education is an extremely important part of treatment as well and will work diligently to accommodate any special request from your child's school.

Enrollment Procedures:

Upon admission, Sundance will ask each parent/legal guardian to sign a release of records to communicate with the child's school (counselor and/or administrator). Parents/ Legal Guardians are responsible for withdrawing their child from their local school on their first day of admission or request work be sent to Sundance. **This is the parent's/ legal guardian's choice. Sundance is not able to withdraw the child from school for you.** The Educational Coordinator will contact the designated school upon admission in order determine the core courses in which the student needs to be placed and to obtain current grades/records that will be updated by Sundance.

School Procedures:

Progress reports will be sent home for parent/ legal guardian upon request. Sundance will follow Arlington ISD calendar for in-service dates, holidays, breaks, and grading periods. **STAAR test dates need to be discusses with each school individually (We do not provide the STAAR testing at this facility).**

Discharge Procedure:

The Educational Coordinator will contact the last school the child attended with the proposed discharged date for the client. On the day of discharge grades will be directly sent to the child's previous school or given to the parent/ legal guardian if the child is changing schools. Parents/ legal guardians will also receive a copy upon discharge for their records.

Contact:

Education Coordinator
Sundance Center Arlington
Xavier Phillips
Xavier.Phillips@sunbhc.com
817.583.8066

**Sundance School
Educational Registration Form**

Student Information:		Enrollment Date:
Last Name:	First Name:	Middle Name:
SSN:	Birth Date:	Student ID:
1 st Parent/Legal Guardian:	Primary Number:	Email:
2 nd Parent/Legal Guardian:	Primary Number:	Email:
Street Address:	City & State:	Zip Code:

School Name:	School District:	Grade:
School Contact:	Position:	Phone Number:
Special Education: <input type="checkbox"/> Yes <input type="checkbox"/> No	Advanced Classes: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of School Returning to after Treatment:
CLASS SCHEDULE:	TEACHER:	PASS/FAIL:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
Special Concerns:		

*****PLEASE NOTE: IT IS THE RESPONSIBILITY OF THE PATIENT'S PARENT/ LEGAL GUARDIAN TO WITHDRAW THEIR CHILD FROM THEIR CURRENT SCHOOL *****

Authorization for Release of Academic Information

I hereby authorize Sundance Behavioral Healthcare, Inc.
7100 US 287 Hwy
Arlington TX 76001

To obtain from: _____ Academic Records obtained during the course of treatment of:

_____ (School)	_____ (Patient Name)
_____ (Street Address)	_____ (Date of Birth)
_____ (City, State, Zip Code)	_____ (Social Security)
_____ (Phone Number)	
_____ (Fax Number)	

Disclosure is necessary for the purpose of ACADEMICS/GRADES and that purpose only. I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses. Information to be released includes (Please check documents to be disclosed pursuant to this authorization).

- | | |
|---|---|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Assessments |
| <input type="checkbox"/> Lab work/Testing Results | <input type="checkbox"/> Other, please list: _____ |
| <input type="checkbox"/> History and Physical Exams | <input type="checkbox"/> Verbal Communication with: |
| <input type="checkbox"/> Consultation Report | _____ (Name) |
| <input type="checkbox"/> Treatment Plan | _____ (Relationship) |

I understand that information in my academic record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 180 days (six months).

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality articles. If I have any questions about disclosure of my health information, I can contact Sundance Behavioral Healthcare, Inc.

Patient Name

Parent/Legal Guardian Signature

Date

Staff/Witness Signature

Date

Signature Confirmations

Patient Name: _____

Admission Checklist	I have read and understand Sundance Behavioral Healthcare's admission items.
Individual Family Therapy	I have read and understand Sundance Behavioral Healthcare's Individual Family Therapy Policy.
Home Sheets	I have read and understand Sundance Behavioral Healthcare's Home Sheet Policy.
Treatment Program Rules	I have read and understand Sundance Behavioral Healthcare's Treatment Program Rules.
Dress Code	I have read and understand Sundance Behavioral Healthcare's Dress Code Policy.
Safety Plan	I have received an explanation of my responsibilities and agree to follow them as part of the safety plan for my child while my child is in treatment at Sundance Behavioral Healthcare.
Attendance Policy	I have read and understand Sundance's Attendance Policy and agree to abide by it to the best of my ability.
Subpoena Policy Information	I have read and understand Sundance Behavioral Healthcare's Subpoena Policy.
Behavioral Interventions	I have read and understand Sundance Behavioral Healthcare's Behavioral Interventions Information.
Admissions and Treatment Guidelines	I have read and understand Sundance Behavioral Healthcare's Admissions and Treatment Information and Guidelines.
Overview of Program	I have read and understand the requirements of the program and agree to abide by the requirements. This will be filed in your child's record.
Physician Fees	I have read and understand the non-inclusive physician fee information. I agree to call the physician's office to make payment arrangements within 24 hours of admission .
Patient Rights	I have received an explanation and a copy of the patient rights of Sundance Behavioral Healthcare.
Grievance Policy	I have received an explanation and a copy of the grievance procedure of Sundance Behavioral Healthcare.
Authorization for Outside Speaker	I give my child permission to participate in groups with outside speakers. I also understand that I may rescind this permission at any time by speaking with my child's therapist.
Transportation Authorization	I have read and acknowledged the transportation rules and procedures and agree to abide by them. (If applicable.)
Before/Aftercare Authorization	I have read and acknowledged the Before/Aftercare rules and procedures and agree to abide by them. (If applicable.)
Educational Program and Procedures	I have read and understand Sundance Behavioral Healthcare's Educational Program and Procedures and Educational Registration Form

Patient Name

Parent/Legal Guardian Signature Date

Staff/Witness Signature Date