Crescent Community Services, Inc.

2550 Nature Park Drive, Suite 180
North Las Vegas, NV 89084

Tel/Fax: (888) 353-7336
Email: admin@ccsnv.org

CONSENT FOR TREATMENT

Consent

By signing this agreement, you are giving voluntary consent to participate in treatment with Crescent Community Services, Inc. This permission is given with the understanding that the mission of Crescent Community Services is to prepare individuals with Autism Spectrum Disorder and other behavioral disorders for a world of unlimited possibilities by using our core competencies of innovative, individualized behavioral therapy combined with skills instruction and modern assistive technology, delivered in a safe and sensory-friendly environment. Treatment services may consist of counseling, therapy, and teaching specific life skills to assist individuals in dealing with personal issues which affect the individual and family. Such family issues may include grief and loss, anger management, parenting skills, self-esteem, family separation, reunification, and many more.

Treatment Providers

The clinical staff at Crescent Community Services is comprised of Neuropsychologists, Registered Behavioral Therapists, Interns, and Supervisors with Bachelor's and Master's Degrees. The professional level of the provider assigned is dependent upon the needs of the individual and family. The credentials of providers range from high school diploma to licensed practitioners.

Confidentiality

Privacy and confidentiality are your rights which are protected by state and federal laws. Therefore, all information disclosed to your therapist and generated in your sessions will be kept strictly confidential unless you provide written authorization to release information. However, Crescent Community Services is mandated by law to disclose confidential information to appropriate authorities under the following circumstances: 1) If there is reasonable suspicion of child abuse or neglect or abuse or neglect of a dependent elder; 2) when a court order is issued for records; or 3) when the client or another is in clear and immediate danger. If you threaten to harm yourself, someone else, or the property of others, your treatment provider is required to call the

proper authorities and to take reasonable steps to warn the potential victim and prevent the threatened harm. In these cases, only the minimal amount of information necessary will be shared with the appropriate family members or authorities to ensure your safety and that of others. Additionally, when submitting claims to Medicaid or other insurance carriers, information such as presenting symptoms, diagnoses and treatment progress must be included in order to have services authorized.

Participation in Treatment

As a client of Crescent Community Services, you have the right to be involved in the treatment planning which will identify specific goals, objectives and various therapeutic interventions to help resolve those issues. Likewise, you have the right to be informed regarding your progress. Keep in mind that progress occurs at different rates for different individuals and symptoms may initially increase when addressing painful issues. However, if at any time you are experiencing significant distress or are dissatisfied with your progress or the services you are receiving, it is important to discuss this with our Executive Director. We also ask that you do not terminate treatment without a final meeting with our Executive Director in order to ensure appropriate closure and to provide you with any necessary referrals.

Appointments / Cancellations

Appointments are mutually arranged between you and the Administrative Staff and in order for treatment to be most effective attendance should be regular and consistent. If you are unable to keep your appointment which has been reserved for you, please contact our office at least 24 hours in advance. If 3 scheduled appointments within a 90-day period are missed, without 24-hour notice, services may be discontinued and your insurance provider notified.

After Hours Emergency Contact Procedures

Crescent Community Services has an after hour answering system in order for clients to leave a message, which will be responded to the next business day. To leave a message, please call our office at (888) 353-7336. However, in the event of an emergency, calls should be directed to the local emergency center by calling 911.

Change of Information

Recipients are to **immediately** notify Crescent Community Services at (888) 353-7336 regarding any changes of demographic information (i.e. home address, telephone number). Also, recipients are to **immediately** notify Crescent Community Services regarding any changes in their insurance/Medicaid eligibility and/or funding status from other sources.

As indicated by my initials below, I am providing consent for the following treatment services (actual services rendered will depend upon the needs of the client):

________ **Applied Behavior Analysis (ABA)** Is based on the science of learning and behavior. This science includes general "laws" about how behavior works and how learning takes place. ABA therapy applies these laws to behavior treatments in a way that helps to increase useful or desired behaviors. ABA also applies these laws to help reduce behaviors that may interfere with learning or behaviors that may be harmful. ABA therapy is used to increase language and communication skills. It is also used to improve attention, focus, social skills and memory. ABA can be used to help decrease problem behaviors.

________ **Clinical Assessments** - Assessments such as the CASII and Comprehensive Mental Health Assessments are completed to determine whether or not there is severe emotional disturbance; to identify treatment issues and needs, and to make recommendations for treatment including level of treatment and services. Information obtained during the assessment will be shared with the legal guardian and identified members of the treatment team, as well as the current insurance provider if submitting a claim.

________ **Speech Therapy** - Assess and treat individuals with speech, language, voice, and fluency disorders. May select alternative communication systems and teach their use.

________ **Occupational Therapy** - Assess and administer rehabilitative programs that help build or restore vocational, homemaking, and daily living skills, as well as general independence, to persons with disabilities or developmental delays.

I am providing consent for the following activities as indicated by my initials below:

________ **Photographs and Video.** In order to promote a safe and secure environment, Crescent Community Services has placed video cameras in various locations in our facility. Photographs and/or video may also be taken during agency activities and functions for training purposes.

________ **Use of the Internet** Children using the internet are supervised by staff at all times. While at Crescent Community Services, children are not allowed to access Social Media, chat rooms, or sites determined by staff, administration or parents to be objectionable. Children are not allowed to provide any identifying information.

I have been fully informed regarding the above mentioned treatment services and activities. I understand the information contained in this Consent for Treatment and have received a copy for my records. I acknowledge that I am providing voluntary consent for these services and activities as indicated by my corresponding initials and by my signature below. I understand that I may withdraw my consent with Crescent Community Services at any time by informing the agency in writing.

______________________	______________________	________
Printed Name of Client	**Signature of Client**	**Date**
______________________	______________________	________
Printed Name of Legal Guardian	**Signature of Legal Guardian**	**Date**

I acknowledge that I have fully reviewed the above Consent for Treatment with the above mentioned client and legal guardian.

______________________	______________________	________
Name of Clinical Professional	**Signature of Therapist / Intern**	**Date**

Please click this button to submit your completed packet via email ---------->