Parent Permission Form & Informed Consent

Group Therapy

Welcome! Your child has been selected to participate in a Capital City Youth Services (CCYS) group at his/her school. CCYS is a non-profit agency that has been providing quality services to children and families for close to 20 years. Our small group activities in schools are developed to improve academic success, build healthy relationship skills, and support the healthy development of each child we serve. Our services are voluntary and there is no cost to you or your child for these services. Please take a moment to read and complete this form. If you have any questions or concerns, please contact us at (850) 576-6000.

Youth Name: _____ Date of birth: _____ Gender: _____

Address: _____

City: _____ State: _____ ZIP: _____ County: _____

Race *(circle one)* American Indian Alaskan Native Asian Black Hawaiian/Pacific Islander White Multiracial Other

Ethnicity *(circle one)* Non-Hispanic Hispanic Haitian Jamaican Other Religious affiliation _____

GENERAL CONSENT

I understand that my child will receive services from CCYS. These services may include, but are not limited to: case management, assessment, referrals, psycho-educational groups, group counseling, family counseling, and/or educational services. I understand that a CCYS counselor will be contacting me to obtain additional information so that my child receives the best services possible.

COMMUNICATION & CONFIDENTIALITY

Client records are kept confidential. Information will only be released under the following circumstances: (a) with my consent; (b) clear and eminent danger to self or others; (c) suspected abuse/neglect of a child, disabled adult, or aged person; (d) suspected gang involvement; (e) state/federal data collection for the purpose of research and evaluation; (f) Quality Assurance record reviews; (g) clinical staffings; or (h) a court order. Cases are routinely discussed as part of clinical supervision. CCYS staff has my permission to communicate with my child's school. In order to continually improve our services, CCYS routinely contacts clients (children and parents) following discharge for a period of up to 18 months to conduct follow-up surveys.

COST & ATTENDANCE

I understand that CCYS services are provided for free to me and my child(ren.) Due to the high demand for our services, if a child fails to maintain regular contact with the assigned case manager/counselor, CCYS may terminate services.

COUNSELING TOPICS

Counseling topics may include, but are not limited to: anger management, social skills, study skills, problem resolution, bullying, gangs, safety, drug/alcohol abuse, sexually transmitted diseases (STD's), sexual abuse, suicide, and self-harm.

TERMINATION OF SERVICES

You may terminate services at any time and for any reason. In cases where it becomes necessary for CCYS to terminate a client's services due to behavioral or other concerns, future requests for services (residential or non-residential) will be determined on a case-by-case basis.

GRIEVANCES AND FEEDBACK

CCYS strives to provide quality professional services to every family we serve. Feedback is always welcomed and encouraged. If you are not satisfied with the service provided or if you have questions, concerns that you feel have not been properly addressed after speaking with the advocate, please request to speak with your advocate's supervisor. Grievances can be directed, verbally or in writing, to any member of management and will be responded to in a timely manner.

I understand that CCYS makes no provision or guarantee as to the results of its efforts. I also understand that I will be notified immediately if there are any changes in my child's circumstances. I have read and understand the information above and I agree to abide by all terms. My signature below also indicates that I have received copies of the CINS/FINS informational brochure.

Parent/Guardian Information

Parent/guardian name _____ Relationship to child _____

Street address _____ City/State/ZIP _____

Home phone # _____ Cell phone # _____ Work phone # _____

The insurance information below is collected only for the purposes of making referrals, if necessary. Your insurance WILL NOT be billed for any reason. CCYS will not contact anyone regarding you or your child without first obtaining your permission

Name of child's physician: _____ Health insurance provider _____

_____ _____ _____

Parent/Guardian Name (please print) Date Parent/Guardian Signature

Staff use only: *Please note the date that a copy of this form was mailed to parents* _____