CCYS Informed Consent Agreement
Individual Therapy

I understand that my child, _____, will receive services from CCYS. These services may include, but are not limited to: shelter, food, clothing (as needed), case management, assessment, referrals, psycho-educational groups, family counseling, and educational services. I also understand that CCYS will provide/facilitate transportation to school as well as other therapeutic or recreational activities. My active participation in the CCYS program, including contact with my child's advocate and attendance at scheduled meetings is necessary for total care of my child.

(parent/guardian initials next to each heading)

COMMUNICATION & CONFIDENTIALITY

____ Client records are kept confidential. Information will only be requested and/or 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; (h) a court order; (i) any other agencies providing counseling, psychological services, or substance abuse treatment to the youth; or (j) any physician treating the youth. Cases are routinely discussed as part of clinical supervision. CCYS staff has my permission to communicate with my child's school, when necessary, and with the referral source. 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.

APPOINTMENTS

____ Family involvement is an integral part of the CCYS treatment philosophy. As such, we require that parents/guardians participate in our services on a regular basis. Should an appointment need to be rescheduled, CCYS requests at least 24-hour notice. In the event that my family misses an appointment without notifying their assigned counselor, the appointment time may be reassigned. Due to the high demand for our services, if a family 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: drug/alcohol abuse, sexually transmitted diseases (STD's), sexual abuse, suicide, and self-harm.

AUDIO/VIDEO MONITORING

____ CCYS utilizes an audio and/or video monitoring system in the public areas and that the system is recording 24 hours a day. Additionally, some counseling sessions may be monitored via a closed-circuit audio/video system. All audio/video recordings will be secured in keeping with our confidentiality policies.

TERMINATION OF SERVICES

____ Residential services may be terminated by CCYS for a client's violation of program rules, refusal to cooperate with staff, refusal to work in counseling, and/or falsifying information at Intake. If it becomes necessary to terminate residential services, as the legal guardian I will be responsible for taking custody of the child and providing adequate living arrangements. You may terminate services and remove your child at anytime. In cases where it becomes necessary to terminate a client's services, future requests for services (residential or non-residential) will be determined on a case-by-case basis. Failure to respond to a request for discharge in a timely manner may be considered abandonment.

MEDIA (If you wish to opt out, please initial here ___)

____ I hereby authorize CCYS to use, reproduce, and/or publish all written and/or visual materials, including photographs, which may pertain to my child. I understand that this material may be used in various publications, public affairs releases, recruitment materials, or for other related endeavors. This material may also appear on the CCYS web page. This authorization is continuous and may only be withdrawn by my specific rescission of this authorization. Consequently, CCYS may publish materials, use my name, photograph, and/or make reference to me in any manner that the agency or project sponsor deems appropriate in order to promote/publicize service opportunities. CCYS *will not* release any treatment- or medical-related records to the media.

GRIEVANCES AND FEEDBACK

____ *Non-residential* - 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.

Residential Residents can, at any time during their stay, file a grievance against the program or a staff member. Forms and a locked box are located in the main shelter area. Please refer to the Residential Contract or the Resident Manual for more information.

MEDICAL CONSENT (Residential services only)

____ I give consent to any hospital, clinic, physician, or dentist to administer necessary treatment to the above named child in an emergency when I cannot be contacted. I give consent for the above named child to be transported by ambulance if necessary. I agree to assume all costs relevant to the above named child's medical treatment. I give consent for the staff of CCYS to provide Over the Counter (OTC) medicines to the above named child. I have indicated all OTC medication restrictions below. I give consent for the staff of CCYS to provide prescription medication to the above named child, and I understand I am responsible for providing these medications in the original container, and that they <u>will be provided as directed on the label</u>. I understand that I will also be responsible for providing refills.

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 above contract and I agree to abide by all terms. **My signature below also indicates that I have received the Program Overview & Guidelines/Rights & Responsibilities.**

Print Client Name	Client Signature	Date
Print Parent/Guardian Name	Parent/Guardian Signature	Date
Print Staff/Witness Name	Staff/Witness Signature	Date

Residential clients only:

Name & Phone of primary physician: _____ *Insurance company & policy #:* _____

List any OTC restrictions or allergies: _____