CLIENT RIGHTS & RESPONSIBILITIES and CONSENT FORM for COLLABORATIVE IN-HOUSE THERAPY (CIT)

The Jewish Social Service Agency ("JSSA") is pleased to provide you with Collaborative In-house Therapy. We will do our best to serve you well. As an individual receiving this service,

You have the right to:

1. Competent, concerned, individualized care without regard to race, color, sex, sexual orientation, age, religion, national origin, marital status, political belief, or disability.
2. Be treated with dignity, consideration, and respect.
3. Be informed about (a) the general goals and timelines proposed for your therapy/service, (b) the diagnosis of your condition if applicable, (c) the risks and benefits associated with your treatment/service, (d) the alternatives to the proposed therapy/service available to you, (e) the risks of not being treated/served, and (f) the prospects for treatment/service success.
4. Ask about our professional qualifications and education backgrounds.
5. Discuss any concerns you have about care with your worker. If you desire, you may also request a private conference with your worker's supervisor, Department Director, or Chief Operating Officer of JSSA to resolve any problems you have with the professional services you are receiving.
6. Be notified in advance, if possible, about necessary changes in the worker assigned to your case.
7. Make suggestions as to how our services may be improved.
8. Be informed in advance about JSSA's charges for the services you will receive.
9. Question and discuss your payment obligations, your bills, and other related payment concerns with the Billing Supervisor.
10. Be informed about our policies and procedures to protect your privacy to the fullest extent under state and federal law, and make an informed decision about whether you want your worker to communicate via e-mail with you and/or your legal representative or other individuals involved in your case.

You have the responsibility to:

1. Actively participate in your own treatment/service.
2. Provide accurate information, including financial data, as required.
3. Know your own insurance information and benefits coverage, including deductibles and co-payments.
4. Pay your agreed upon fee or co-payment at the time of service, and be responsible for any outstanding balance.

CONSENT TO ABIDE BY JSSA'S STATEMENT OF CLIENT RIGHTS AND RESPONSBILITIES

I have received, reviewed, understand and agree to abide by JSSA's statement of client rights and responsibilities

_____ _____

Client/Patient - Please print name Date

_____ _____

Signature of Client/Patient (required for 14 yrs+) Date

_____ _____

Parent, Guardian, or Personal Representative* Please print Date

_____ _____

Signature of Parent, Guardian, or Personal Representative* Date

***Form completed by PCP Gatekeeper with Youth/Parent before scheduling CIT Appointment**

CONSENT TO COLLABORATIVE IN-HOUSE THERAPY (CIT)

A licensed and qualified mental health professional will meet with you and your child/adolescent. During this time, the mental health professional will:

- Review all the information provided by the primary care physician
- Discuss with you and your child/adolescent (either separately or together) about any concerns you or your child/adolescent have related to mental/behavioral health functioning
- Review recommendations for next steps (including providing you and your child/adolescent with educational and/or referral information).
- Information, including any recommendations resulting from the assessment will be shared with your child's primary care physician.

The fee for this service is $150.00
Attendance Policy:

- If you are unable to keep the scheduled appointment, you must cancel the appointment with at least 24 hour notice in order to avoid a cancelation fee.
  If you do not attend the scheduled appointment and do not cancel the appointment, you will be charged a missed appointment fee of $65.00.
- You and your child/adolescent need to arrive 10 minutes prior to the scheduled appointment time.
- If you are more than 30 minutes late for your scheduled appointment it will be canceled and you will be charged a cancelation fee. JSSA is an in-network with Aetna, BlueCross BlueShield, Cigna, Medicare, MHN, Tricare, United Behavioral Health, and United Healthcare.

Capital Area Pediatrics will share your child's insurance information with JSSA prior to the appointment and you will be responsible to pay your required co-pay at the time of the appointment.

We do not accept DC Medicaid or Virginia Medicaid, or Kaiser. If your insurance is not listed here, we may be able to use your out-of-network benefits, on a case-by-case basis. If you do not have insurance, or if your insurance does not have any mental health benefits, we may be able to offer a sliding scale that is based on your household income, assets, and expenses. Acceptable methods of payment are: Credit or Debit Card, or check, money order made payable to JSSA. You will receive a receipt via first class mail within 7-10 business days of your appointment.

I have received, reviewed, understand and provide my consent to participate in the assessment, referral and connection screening.

_____ _____
Client/Patient - Please print name Date

_____ _____
Signature of Client/Patient (required if 14 yrs+) Date

_____ _____
Parent, Guardian, or Personal Representative* Please print Date

_____ _____
Signature of Parent, Guardian, or Personal Representative* Date

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES FORM

Permissible Disclosures of Your Information

JSSA's privacy practices are described in full in JSSA's Notice of Privacy Practices (a copy of which will be provided to you separately). In addition to reading the full Notice of Privacy Practices, you should pay particular attention to the following limitations and restrictions:

(i) JSSA will not release your records to anyone outside JSSA and Capital Pediatrics without written authorization from you except when confidentiality poses an imminent danger to you or others or when otherwise **permitted or required by law. Information contained in your record (other than psychotherapist notes)** may be disclosed to JSSA employees, agents, and volunteers **or third party payers for the purpose of providing you with** the most effective service/treatment, **obtaining payment or auditing or evaluating** our records.

(ii) State law requires us to report all suspected cases of abuse and/or neglect of children and vulnerable adults. This reporting requirement includes unreported past abuse.

(iii) If your record contains substance abuse information received from a federally assisted drug or alcohol abuse program, there are specific Federal regulations which may apply in addition to the regulations that apply to all medical records in JSSA's possession. JSSA will not disclose to anyone outside of JSSA any information received from a federally assisted drug or alcohol abuse program (including the fact that you are receiving services from the substance abuse program) except as permitted by law in the following circumstances: (1) if you provide written consent to release such information, (2) in the case of medical emergency, (3) when ordered by a Court, or (4) for audit or evaluation of our records.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that the privacy practices and policies described in this document do not fully describe JSSA's Privacy Practices, and I acknowledge that a full description of JSSA's privacy practices can be found only in JSSA's Notice of Privacy Practices.

I also hereby acknowledge that I have received a copy of JSSA's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact JSSA's Privacy Officer at 301-838-4200.

_____ _____

Client/Patient - Please print name Date

_____ _____

Signature of Client/Patient (required if 14 yrs+) Date

_____ _____

Parent, Guardian, or Personal Representative* Please print Date

_____ _____

Signature of Parent, Guardian, or Personal Representative* Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

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COMPREHENSIVE FACE SHEET for JSSA Referral

Parent/Guardian

First Name:	Last Name:
Street Address:	City:
State:	ZIP Code:
Home Phone Number:	Work Phone Number:
Cell Phone Number:	Email Address:

Child/Adolescent

Full Name (as listed on their insurance card):	
Child's Nickname:	
Child's Date of Birth:	Sex:

Parental Custody Status:

o Married o Divorced - 1 parent custody o Single - 1 parent custody o Guardianship	o Separated - custody TBD o Divorced - shared custody o Single - shared custody

Child's Religion:

o Catholic o Jewish o Muslim o Protestant o Other o No Affiliation

Child's Race:

0 African American	0 Native American	0 Asian	0 Hispanic
0 Mixed Race	0 White	0 Other	

Annual Gross Household Income:

0 $0 - $25,000 o $25,000 - $50,000 o $50,000 - $75,000

0 $75,000 - $100,000 o $100,000

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Name: Sex: Age: DOB:

COMPREHENSIVE FACE SHEET ITEMS

Insurance Information:
Insurance Company (BCBS, Aetna, Medicare, Medicaid):
If this is a Medicaid policy, what is the Medical Assistance#:

Member ID Number: Group Number:
Policy Holder's Name: Policy Holder's Date of Birth:

What is the relationship of the policy holder to the client (mother, father, self)?
Policy Holder's Employer:
Phone number for insurance benefits/providers/customer service:

Do you have Secondary Insurance? D Yes D No
If yes, please complete Secondary Insurance below:

Secondary Insurance Company (ex. BCBS, Aetna, Medicare, Medicaid):
If this is a Medicaid policy, what is the Medical Assistance#?

Member ID Number: Group Number:
Policy Holder's Name: Policy Holder's Date of Birth:

What is the relationship of the policy holder to the client (mother, father, self)?

Policy Holder's Employer:

Phone number for insurance benefits/providers/customer service:

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