Center for Child Development

School counseling component

The Center for Child Development provides professional therapists who partner with school districts to provide mental health services directly in the schools. The therapists are trained to handle issues such as depression, anxiety, self-esteem, poor social skills, anger management, etc.

Counseling is offered on a voluntary basis and provided in the school setting. Services include individual, family and group counseling, as appropriate. Counseling will not conflict with academics; rather it is hoped that it will enhance academics as well as, other aspects of the child's and family life.

*Your school district does not pay for counseling services. Therapists will bill your insurance company. You are responsible for any amount remaining after insurance payments--this excludes Medicaid payments. Please make sure you understand what this entails before signing this form. You are responsible for copays, deductibles, and co-insurance. We require all clients with a commercial insurance plan to keep a credit card authorization form on file that permits us to charge your co-pay/deductible after each session. If you'd instead not hold a credit card on record, you must pay after each session by calling the office.

If your child is already in therapy, please do not complete before ending with the current therapist. We are professional therapists, so your child cannot see more than one at any given time.

Please note, we do not accept the following insurance plans:

Tri-care

Keystone

Magellan

Cigna

Please visit www.thecenterforchilddevelopment.com for our HIPAA privacy policies. If you have any questions about the procedure, please feel free to call the office at 302-292-1334 x101

260 Chapman Road 107

Newark DE 19702

Child's name_____ _DOB_____

Circle M F Transgender Race _____(optional)

Address: _____

City _____State _____Zip Code_____

Name of Parent/Guardian_____

Parent's email address_____ Would you like to receive electronic newsletters and practice blog updates? Yes No

Telephone number_____ Cell Phone number_____

School Child attends_____Grade_____

Primary Care Physician_____

Is the child on any medications? If yes, please list_____
_____

Who prescribes your child's medication? _____

Does the child have any health problems that we should know about? Please circle? Y/N. Please describe_____

Insurance Information Please answer all questions.

Name of Insured_____ Birth date of Insured_____

ID#_____Group#_____

Insured's employer_____Name of Insurance Company_____

Secondary Insurance (is your child covered by another plan?)

Name of Insured_____DOB_____

Name of Insurance company_____

ID #_____

By signing below, you are giving the therapist and CCD permission to bill your insurance company for services. You are also providing the therapist permission to release information necessary to charge the insurance company. Your therapist will only release information that is necessary for billing purposes. You also agree to pay any co-pay/deductible/coinsurance or claims not reimbursed by the insurance company except in the case of Medicaid.

Signed_____Date_____

Informed consent for assessment and counseling

Student name_____

I understand that all information shared with the therapist is confidential and no information will be released without my consent. During counseling, it may be necessary for the therapist to communicate with my child's teachers, school staff, and administration. While written authorization will not be requested, I understand that the therapist will discuss communications with me. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary for special circumstances. I, further understand that there are specific and limited exceptions to this confidentiality, which include the following:

- When there is the risk of imminent danger to the child or another person, the therapist is ethically bound to take the necessary steps to prevent such danger.

- When there is the suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the therapist is legally required to take steps to protect the child and inform proper authorities.

- When a valid court order is issued for medical records, the therapist is bound by law to comply with such requests.

- Please note that insurance companies occasional request medical records to perform audits. By signing this form, you are giving the therapist permission to send your child's records to the insurance company for auditing purposes. If you have concerns about this, please speak with the therapist assigned to your child.

LITIGATION LIMITATION: Due to the nature of the therapeutic process, which often involves making a full disclosure concerning many matters that may be of a confidential nature. It is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits), neither you nor your attorneys nor anyone else acting on your behalf, will call on your (or your child's) therapist to testify in court. This includes at any other proceeding, nor will disclosure of the psychotherapy records be requested. If this occurs, you will be billed $1040.00 as a retainer. The fee of 1040.00 must be paid in full (cash or credit card) within 24 hours before the court date. You will be billed for any time that extends beyond 8 (eight) hours at the rate of 130.00 for a court appearance. It will have to be paid before your next appointment. Please note, we also charge a fee of 200.00 for records preparation. Court fees are not reimbursable by your insurance company. If this occurs, you will be billed $1040.00 as a retainer. The payment of 1040.00 must be paid in full (cash or credit card) within 24 hours before the court date. You will be billed for any time that extends beyond 8 (eight) hours at the rate of 130.00 for a court appearance. It will have to be paid before your next appointment. Please note, we also charge a fee of 200.00 for records preparation. Court fees are not reimbursable by your insurance company.

- Last, you understand that most insurance plans subscribers have some financial responsibility. You will be billed weekly for any co-pay, co-insurance or deductible. If you fail to pay after three sessions, your therapist has the right to refer you to a community agency for services. If you are unclear about your insurance coverage, call the number on the back of the card and ask them about your mental health coverage.

I understand that counseling services are provided by a range of mental health professionals some of whom are in training. Licensed staff supervises all professionals- in- training. You will be notified in writing if the therapist is a pre-licensed professional and working under the supervision of a licensed therapist.

If I have any questions regarding this consent form or about counseling, I will discuss them with the therapist. I have read and understood the above. I consent to allow my child to participate in the assessment and counseling offered. I know I may end treatment at any time.

Signature_____Date_____

Problems and Concerns.

What is your biggest concern for your child?

Do you have concerns that your child is at risk for self-harm?

Has your child been in counseling previously? If so where and what were the results?

What goals would you like counseling to help you and your child to achieve?

If necessary, are you willing to participate in the counseling process? We have private offices in Newark to accommodate working parents.

Billing questions? Please call:

302-292-1334 x101

Fax number 866-230-6434

Office policies

TELEPHONE & EMERGENCY PROCEDURES: If you need to reach your (or your child's) therapist between appointments, you may leave a message 24 hour a day, seven days a week, on his/her voice mail at (302) 292-1334. If your call is urgent, and a therapist does not call you back immediately, please call the Rockford Center Needs Assessment at (302) 996-5480, Psych Crisis of Christiana Care Health Systems at (302) 428-2118, the Crisis Intervention Services at (302) 577-2484 or (800) 652-2929, or Meadow Wood Hospital at (302) 328-3330. If your call is a life-threatening emergency, you should go immediately to the closest hospital or call 911.

PAYMENTS: Site visits, report writing and form completion, more extended sessions, the non-contractual rate of 130.00 per pro-rated hour. Requests to release your records will be subject to an administrative charge.

Please note that your payment is due at the time of your visit. As part of your insurance plan, you signed an agreement that you will pay your co-pay, deductible, and co-insurance. We require a credit card to be kept on file with authorization to charge your fees after each session. (see attached)

Social Media Policy

To maintain your confidentiality and our respective privacy, we do not interact with current or former clients on social networking websites. Your therapist will not accept friend or contact requests from current or former clients including, Twitter, Facebook, LinkedIn. We will not respond to friend requests or messages through these sites.

We will not solicit testimonials, ratings, or grades from clients on websites through any means. We will not respond to testimony, evaluations or grades on sites, whether positive or negative, to maintain your confidentiality. We hope that you bring concerns about our work together to the therapy session so that we can address concerns directly.

HIPPA POLICY

Please see and read attached. It is also available on our website and in the office.

Please sign indicating you've read our office policies.

Signature_____Date_____

CCD school year 2018-2019