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**PLEASE REVIEW PRIOR TO 1st APPOINTMENT WITH
YOUR THERAPIST. YOU WILL BE ASKED TO COMPLETE
FORM DURING YOUR INITIAL APPOINTMENT.**

C.A.S.E.: _____

Informed Consent for the Center for Adoption Support and Education Clinical Services

The Center for Adoption Support and Education, Inc (C.A.S.E.) welcomes you and your family.

This informed consent document is intended to give you general information about our counseling services and to obtain your informed consent. Please read it carefully before signing. If you have any questions about signing this document, please ask your therapist, _____
You will receive a copy of this signed document for your records.

***NOTE:** If completing form electronically, you agree that entering your name in any signature box in this document constitutes your electronic signature and the date signed.*

SERVICES and STAFF

The Center for Adoption Support and Education (C.A.S.E.) is a professional, nonprofit agency offering a wide range of adoption-competent counseling services. These services are provided by mental health professionals and graduate-level interns with a strong interest and knowledge base in adoption-related issues. In all cases, therapists are supervised by a licensed mental health professional or a team that includes a licensed mental health professional with specialized training in the field of Adoption Competency. In addition to providing direct counseling services, this agency provides training, and consultation, and engages in research.

CLIENT'S RIGHTS and RESPONSIBILITIES

YOUR RIGHTS

- You have the right to be treated with courtesy, dignity, and respect and without discrimination.
- You have the right to be involved in the development of your plan for services.
- You have the right to refuse services.
- You have the right to receive services delivered in a competent and ethical manner.
- You have the right to be informed of and consent to any fees charged for services rendered, in the case of a client who is a minor, the parent or legal guardian will be informed and provide consent, and be responsible for payments.
- You have the right to refuse to participate in research or agency public relations.
- You have the right to confidentiality, which is upheld within the limits of the law. (See Statement of Confidentiality)
- You have the right to file a grievance if dissatisfied with services and to receive assistance in the grievance process. (See Client Grievance Process Statement)
- You have the right to know the qualifications of staff that provide services to you.

CLIENT RESPONSIBILITIES

- You have the responsibility to participate in planning for your services.
- You have the responsibility to give accurate information about your needs.
- You have the responsibility to attend scheduled sessions and to give at least 24 hours' notice if a cancellation needs to occur.
- You have the responsibility to pay agreed upon fees for services.

BILLING and PAYMENTS

- Payment is due at the time services are rendered. Please make checks payable to C.A.S.E. Visa, MasterCard, and Discover are acceptable forms of payment as well.
- Once an appointment has been scheduled, this time is reserved for you. If an appointment is not kept, you will be responsible for full payment of that session unless the appointment is cancelled at least 24 hours in advance.
- Should there be more than two missed appointments (without notification to C.A.S.E.), we reserve the right to discontinue services.
- The time for any additional services such as reports, court preparation/appearances, lengthy phone calls, school visits, i.e., IEP meetings, will be billed at the standard rate.
- If your bill is overdue, then you will be charged a late fee of 2% (with a \$5 minimum charge).
- Based on client need and the availability of funds, C.A.S.E. may be able to provide partial scholarships for services. To be considered for scholarship funds, please discuss with your therapist who will direct you through the proper procedure. You may also request a payment plan which can be arranged by the Finance Department.
- C.A.S.E. reserves the right to increase service fees. When this occurs, sufficient notification will be provided.

CLIENT GRIEVANCE PROCESS

You have the right and will have the opportunity to express and resolve any grievances regarding your contact at the Center for Adoption Support and Education, Inc. (C.A.S.E.). Filing a grievance will not cause an adverse reaction against you and will not become part of your clinical file. A separate confidential record will be kept of all grievances of which you will receive a copy.

C.A.S.E. encourages you to discuss any concerns with the staff person working with you and to seek to resolve the problem through that direct contact. If you are not comfortable speaking with that staff person or feel the matter needs further attention after such discussion, then you may go to the Deputy Director.

If you desire to file a formal complaint, then you may ask any staff person for a copy of the Grievance Form. This form will then be completed and sent to the Chief Executive Officer of C.A.S.E. She will try to resolve the issue raised by the client. If the issue is not resolved satisfactorily, the grievance will be submitted to the Board of Directors for resolution. Grievance solutions must address the problem and may vary from one situation to another. The process will be completed within 15 days from receipt of a written grievance.

EMERGENCIES

In an emergency situation, please go to your nearest emergency room or call 911. C.A.S.E. is not a 24 hour/day crisis counseling facility and when the agency is closed, there is not a staff member on call.

I understand if deemed necessary, my therapist may request to contact a family member, local authorities and/or 911. I understand that in the event of an emergency/crisis, or if the therapist is unable to clearly determine factors to ensure my own safety or that of someone else during the course of services, my therapist has the right to contact the following individual for additional assistance.



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I give permission to have the person below contacted in the event of an emergency.

Name: _____ Relationship: _____

Telephone number: _____

PROFESSIONAL RECORDS

You have the right to request to see your clinical records. The therapist will review and consider this request but does reserve the right to deny this request if it is not in your best interest, or if it will interfere with the clinical progress that is being made in therapy.

COMMUNICATION

C.A.S.E. staff can be reached by calling the main C.A.S.E. office at 301-476-8525 during the following hours of operation: Monday between 8:30 AM and 4:30 PM, Tuesday through Thursday between 8:30 AM and 9:00 PM, and Friday between 8:30 AM and 4:30 PM. At any time, you may leave a confidential voicemail message.

ClientConnect:

C.A.S.E. will need to communicate with you in the normal course of delivering counseling services. This could include, but is not limited to, scheduling appointments, 48 hour appointment reminders, and billing, etc. In order for this communication to be as effective as possible we request your permission to be contacted via various means, including email and telephone. We collect your contact information during our new client intake process, however, request that you update your preferred contact information at anytime that a change is needed.

To facilitate communication we use a mobile client portal called ClientConnect which enables you to more fully participate in your care, including features such as secure and convenient messaging, viewing your upcoming appointments, completing and signing documents, viewing and managing your profile and contact information, and more. Our client portal offers enhanced security of your personal information and communication with your therapist.

In addition, C.A.S.E. would like to be able to communicate with you about various activities of the agency that may be of use and interest to you and your family. These activities could include but are not limited to: our monthly e-newsletter, notices of upcoming program offerings or agency trainings, events and campaigns, or sharing the latest research. You have the right not to be contacted for general agency information. During the new client intake process you indicated your agreement to be contacted, or exercised your right to no contact, for these purposes via the phone number and email you provided. Please contact our intake coordinator, 866-217-8534 if you would like to make changes to the contacts you receive.

If you give permission for your therapist to leave phone messages on your voicemail, please sign here:

Signature

Phone number



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C.A.S.E.: _____

With respect to electronic mail (e-mail), you are cautioned that e-mail outside of our client portal (ClientConnect) is not a confidential means of communication. Furthermore C.A.S.E. cannot ensure that e-mail messages within ClientConnect or outside of our client portal will be received or responded to if your therapist is not available. E-mail is not the appropriate way to communicate confidential, urgent, or emergency information.

If you give permission for your therapist to communicate with you via email, please sign here:

Signature Email address

Please note that if your contact information changes, we kindly ask that you inform your therapist as soon as possible so we can update your records.

RISKS and BENEFITS

It is important for you to know that there are risks from and benefits of therapy. Therapy may involve reflecting on unpleasant events and may arouse strong emotions. The benefits from therapy may involve improved functioning in various areas and treatment goals, as determined in partnership between you and your therapist.

NOTICE OF PRIVACY PRACTICES

You have a right to receive a paper copy of the C.A.S.E. Notice of Privacy Practices.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Center for Adoption Support and Education (C.A.S.E.) staff is required to keep client information confidential in accordance with State and Federal laws and regulations. C.A.S.E. is required to provide you with a Notice of Privacy Practices to explain its privacy practices. Client information will only be released to individuals outside of C.A.S.E. in accordance with such laws and regulations. This Notice explains how patient information is used at C.A.S.E.

Exceptions to Written Authorization

Most releases are only with your express written consent. However, by seeking services from C.A.S.E., you acknowledge that information may be used by the C.A.S.E. staff, without further permission, to communicate with each other about your treatment (e.g., your therapist needs to consult with our interns or colleagues), to seek payment for staff services (e.g., funder/grant/contract requirements or to bill insurance carriers), and for healthcare operations (e.g., quality assurance functions).



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C.A.S.E. is also required to disclose confidential information without your written permission if:

1. You or your child is a danger to himself or others; or
2. Your child's therapist has a reasonable suspicion of abuse or neglect.

We may release information without your authorization in an emergency or for important public health needs. We may also release information without your consent if it has been "de-identified" in accordance with federal law.

C.A.S.E. may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use certain information (name, address, telephone number or e-mail) to contact you to raise funds for C.A.S.E., but you have the right to opt-out of receiving such future communications with each solicitation. We will use the funds raised to expand and improve our services and programs and to help defray costs for families who cannot afford our services. You are free to opt-out of any or all fundraising solicitations and your decision will have no impact on your treatment or payment for services at C.A.S.E.

Your group health plan, health insurance carrier, or HMO may disclose protected health information to the sponsor of the plan.

Releases with Your Written Authorization

Other uses and disclosures will be made only with your written authorization. You may revoke such authorization at any time, although C.A.S.E. may rely on any actions it took before it received notice of the revocation of your authorization.

You have the right to:

- request restrictions on certain uses and disclosures as provided by 45 CFR 164.522(a). C.A.S.E. is not required to agree to a requested restriction.
- receive confidential communications of protected health information as provided by 164.522(b), as applicable
- inspect and copy protected health information as provided by 164.524
- amend protected health information as provided in 164.526
- receive an accounting of disclosures as provided in 164.528
- obtain a paper copy of this Notice upon request as provided in 164.520

C.A.S.E. is required to abide by the terms of the Notice currently in effect at the time you receive treatment, but C.A.S.E. reserves the right to change the terms of this Notice and to make the new notice provisions effective for all protected health information that it maintains. We will provide you with any revised Notice at the time of your next visit to C.A.S.E.

If you believe that your privacy rights have been violated, you may complain to C.A.S.E. and to the U.S. Secretary of Health and Human Services. You may contact the Chief Executive Officer of C.A.S.E. by phone at 301-476-8525 or by mail at 3919 National Drive, Suite 200, Burtonsville, MD 20866 if you have questions or concerns. You will not be retaliated against for filing a complaint.

This notice was updated October 2020.

Client's Signature: _____ Date: _____



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C.A.S.E.: _____

I HAVE DISCUSSED THIS INFORMATION WITH THE CLIENT:

Staff Signature: _____ Date: _____



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C.A.S.E.: _____

Telehealth Informed Consent

The Center for Adoption Support and Education (C.A.S.E.) offers Telehealth, a treatment modality that occurs via interactive video-conferencing (VC), in lieu of, or in addition to, sessions that occur in person at one of C.A.S.E.'s office. Video conferencing (VC) is a real time interactive audio and visual technology that allows C.A.S.E. therapists to provide mental health services remotely. C.A.S.E. uses Zoom (zoom.us), a telehealth platform that meets HIPPA standards of encryption and privacy protection. Clients do not need to purchase a plan or provide their name when "joining" a virtual session via Zoom, but clients must have a computer or other device with a webcam and access to the internet in order to participate in sessions remotely. Although VC may be used when the clinician and client are in different locations, licensure regulations only allow a session to be conducted in the state in which the clinician is licensed, and the client is located.

I understand the risks unique and specific to VC services which may include, but are not limited to: communication becoming distorted or disrupted due to technological difficulties, discomfort with virtual face-to-face interactions vs. in-person treatment, and limited access to immediate resources if risk of self-harm or other harm becomes apparent.

Technology Related Issues :

I understand that I will need to ensure good broadband Internet connection. I am solely responsible for any cost to obtain necessary equipment or accessories to take part in tele-mental health counseling services. For most clients, there are no additional costs incurred. I understand that in the case of technology failure, I will attempt to re-establish connection with my therapist within my allotted appointment time. If I am unable to establish the connection, I will contact my therapist by phone to reschedule my appointment or to coordinate alternative methods for service.

Confidentiality:

I am expected to participate in my tele-mental health counseling sessions from a safe, confidential location that will ensure privacy and minimize noise/ distractions. We do suggest the use of headphones to maximize privacy. I will provide my location at each session and announce any/all other individuals whom are present or within ear shot of sessions. I further understand that my sessions may be deemed inappropriate to continue by the therapist due to any distractions or issues with confidentiality that are present.

Access to Services:

I understand tele-mental health services will not be provided to me if I am outside the state of service agreed upon unless specific permission has been granted to me by my therapist. I understand scheduling appointments is based on my clinician's working business hours.

Tele-mental health services are considered outpatient services and not intended as a substitute for emergency or crisis services. If I am in a state of emergency or crisis, I will contact local resources or 911 if there is an imminent emergency.

I understand that prior to discharge or termination of services for tele-mental health counseling, I will comply with a final tele-mental health counseling session with my therapist.



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Fees :

The same fee rates will apply for tele-mental health services as apply for in-person counseling sessions. Please contact your insurance company prior to engaging in VC sessions to determine your coverage.

Crisis Management Plan:

I understand if deemed necessary, my therapist may request to contact a family member, local authorities and/or 911. I understand that in the event of an emergency/crisis, or if the therapist is unable to clearly determine factors to ensure my own safety or that of someone else in the middle of my session, my therapist has the right to contact the emergency contact provided.

By signing this form, I acknowledge that:

1. My therapist has discussed with me the potential benefits and risks of participating in VC sessions.
2. I am responsible for payment following each Telehealth session. (C.A.S.E. will invoice the client following each session and provide any necessary documentation for submission to client's health insurance provider.).**
3. I understand that I will be billed for any telehealth session that is not cancelled with 24 hours notice.**
4. I have provided my therapist with the appropriate emergency contact information and have discussed with my therapist how I can access local resources if needed.

**This does not apply to clients whose services are covered under a state or county contract.

Client Signature (Parent/Guardian if client is under 18)

Date