Informed Consent for Clinical Services at The Center for Adoption Support and Education

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 clinical 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.

NOTE: A signed consent form is needed for each person who is included in a billed session (i.e. child, parent(s), sibling(s)).

SERVICES and STAFF

C.A.S.E. is a nonprofit agency offering a wide range of adoption-competent counseling services. These services are provided by licensed mental health professionals (therapists) and graduate-level interns under supervision with a strong interest and knowledge base in adoption-related issues. Therapists are supervised by a licensed mental health professional with specialized training in the field of adoption competency. In addition to providing direct clinical and case management services, this agency provides training, consultation, and engages in research.

CLIENT’S RIGHTS and RESPONSIBILITIES

YOUR RIGHTS

- You have the right to be treated with courtesy, dignity, and respect without discrimination. C.A.S.E. serves all families regardless of race, color, religion, gender, pregnancy, age, national origin, disability, sexual orientation, gender identity, gender expression, or any other category protected under applicable federal, state or local law.
- You have the right to receive services delivered in a competent and ethical manner.
- You have the right to refuse service and to terminate services at your will.
- You have a right to receive a copy of the C.A.S.E. Notice of Privacy Practices.
You have the right to refuse to participate in research, agency public relations, or marketing.

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 will be responsible for payments. A fee schedule will be provided prior to service initiation and prior to any increase in fees.

You have the right to know and understand the qualifications of staff who provide services to you.

You have the right to confidentiality, which is upheld within the limits of the law. (See Statement of Confidentiality.)

You have the right to be involved in the development of your service treatment plan.

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.)

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 you need to cancel a session.

You have the responsibility to pay agreed upon fees for services.

BILLING and PAYMENTS

Payment is due at the time services are rendered. Visa, MasterCard, and Discover are acceptable forms of payment. If alternative forms of payment are needed, please contact the finance department 301-476-8525.

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 three 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, 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 C.A.S.E. Filing a grievance will not result in an adverse reaction against you and will not become part of your clinical file. A separate confidential record will be kept of grievances. You will receive a copy of all correspondence that is maintained in the file.

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 contact the Director of Clinical Services.

If you desire to file a formal complaint, then you may ask any staff person for a copy of the C.A.S.E. Grievance Form. After you complete this form, it will be sent to the Director of Clinical Program Administration and the Chief Executive Officer of C.A.S.E. for resolution. If the issue is not resolved satisfactorily, the grievance will be submitted to the Board of Directors for resolution. A response will be provided within 30 days of receipt of a written grievance.

EMERGENCIES

In an emergency, 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 are no staff members on call.

I understand if deemed necessary, my therapist may contact a family member or identified individual below, 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 the safety of another during the emergency, my therapist has the right to contact the following individual (family or friend) for additional assistance.

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 reserves the ethical right to deny this request if it is determined to not be in your best interest, or if it will interfere with the clinical progress that is being made in therapy. In lieu of clinical records a treatment summary may be provided.

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 - Friday: 8:30 AM – 5:00 PM.

At any time, you may leave a confidential voicemail message. This is not an emergency response line. Voicemails will be returned the next business day or as soon as staff are available. If you are calling with a medical or clinical emergency, please hang up and dial 911 or go to your closest emergency room.

ClientConnect:
C.A.S.E. will need to communicate with you in the normal course of delivering clinical services. This could include, but is not limited to, scheduling appointments, 48-hour appointment reminders, billing, etc. For this communication to be as effective as possible, we request your permission to be contacted via various means, including email and telephone. Your contact information will be requested during the client intake process. Please update your preferred contact information anytime that a change is needed.

To facilitate communication, C.A.S.E. uses the mobile client portal via Client Connect. By using the mobile client portal, you will be able to:

- Fully engage your therapist regarding your care.
- Maintain security of your personal information and communication with your therapist.
- Send a secure and convenient message.
- View upcoming appointments.
- Complete and sign documents.
- View and manage your profile and contact information, and more.
In addition, C.A.S.E. requests 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 research findings. You have the right not to be contacted for general agency information. Please contact your therapist and/or the intake coordinator, 866-217-8534, if you would like to make changes to the contacts you receive.

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. E-mail is not the appropriate way to communicate confidential, urgent, or emergency information. 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 the therapist is not available.

Please note that if your contact information changes, we kindly ask that you inform your therapist or the C.A.S.E. intake coordinator as soon as possible.

Texting/Messaging
Text communication with C.A.S.E. staff is for scheduling purposes only. The client/family member scheduling an appointment via text must be at least 18 years of age.

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. It also takes time. The benefits from therapy may involve improved functioning in various areas and treatment goals, as determined in partnership between you and your therapist. Please discuss any concerns you may have with your therapist.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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 client 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 may need to consult with colleagues), to seek payment for staff services (e.g., funder/grant/contract requirements), and for healthcare operations (e.g., quality assurance functions).

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 yourself (themselves) or others; or
2. Your child’s therapist has a reasonable suspicion of child or elder abuse, neglect and/or abandonment.

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 communications. We will use the funds raised to expand and improve our services and programs and to help defray costs for families who cannot afford 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. C.A.S.E. will provide you with any revised Notice as soon as possible.

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 April 2021.

Client’s Signature: _______________________________ Date: _____________
C.A.S.E.: _________
I HAVE DISCUSSED THIS INFORMATION WITH THE CLIENT:
Staff Signature: ________________________________ Date: _______________
Teledhealth 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 the C.A.S.E. offices. 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 therapist and client are in different locations, licensure regulations only allow a session to be conducted in the state in which the therapist is licensed, and the client is located. (These regulations were suspended in some jurisdictions during the COVID19 pandemic.)

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 issues, discomfort with virtual face-to-face interactions vs. in-person interactions, 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 adequate broadband Internet connection. I am solely responsible for any cost to obtain necessary equipment or accessories to take part in telehealth services offered from C.A.S.E. (For most clients, there are no additional costs incurred.)

I understand that in the event 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 telehealth sessions from a safe, confidential location that will ensure privacy and minimize noise/distractions. The use of headphones is suggested to maximize privacy.
I will provide my location at the start of each session and announce any/all other individuals present or within hearing range of sessions. I further understand that my sessions may be deemed inappropriate to continue by the therapist due to distractions or issues with confidentiality that arise.

**Access to Services:**

I understand telehealth 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 therapist’s working business hours.

Telehealth services are considered outpatient services and are not intended as a substitute for emergency or crisis services. If I am experiencing an emergency or crisis, I will contact local resources or 911 if necessary.

**Fees:**

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

**Crisis Management Plan:**

I understand that C.A.S.E. is not a not a crisis intervention mental health organization. Therefore, if I or my family is in crisis, I or my family needs to contact 911 or go to the nearest emergency room. I understand that, if deemed necessary by my therapist, my therapist may contact a family member or approved friend, local authorities and/or 911 to ensure my or my family’s safety. 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, 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 telehealth sessions.

2. I am responsible for payment following each telehealth session. (C.A.S.E. will invoice the client following each session and will provide any necessary documentation for submission to client’s health insurance provider).
3. I understand that I will be billed for any sessions 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, county, private contract.

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

________________________________________________________________________
Date

Keep a copy of this consent form for your documentation. You will sign these forms with your therapist at the time of your initial session.