PARKLAND SCHOOL DISTRICT
Allentown, PA 18104
Student Services (610) 351-5555

CONSENT TO EXCHANGE INFORMATION

I hereby authorize: MindfulKids, LLC
2700 N. Cedar Crest Blvd.
Allentown, PA 18104
Ph: 610-703-9999

to obtain/release information from the records of:

Name of student _____

Date of birth _____

for the purpose of: educational planning

The information to be obtained/released is:

- ☒ Scholastic/Educational Record
- ☒ Academic Evaluations
- ☒ Developmental History/Social
- ☒ Individual Education Plan (IEP)
- ☒ Team Action Plan (IST, SAP, other)
- ☒ SAP Initiated D & A Evaluation
- ☒ Psychological Evaluation/ER
- ☒ Discharge Summary/Aftercare Plan
- ☒ Medical History
- ☒ Psychiatric Evaluation
- ☒ Immunization Records
- ☒ Notice of Recommended Educational Placement (NOREP)
- ☒ Other (specify): *oral and written communication*

PLEASE FORWARD INFORMATION TO THE ATTENTION OF:

Valerie McCall, Ed.S., NCSP / Kelly Theophille, School Psychologists
Name

Parkland School District- Student Services
Address

1210 Springhouse Rd.

Allentown, PA 18104 ph: (610) 351-5610 fax: (610) 351-5658

I have been told that in order to protect the limited confidentiality of records to my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above and will be effective for one (1) year after the date of my signature, unless specified below. I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon.

This consent shall be in effect from _____ until _____

_____ _____
Guardian Signature Date of Signature

_____ _____
Student Signature (14 years of age or older) Date of Signature

MindfulKids Services, LLC
P.O. Box 277
Center Valley PA 18034
Phone: 620 703 9999 / Fax: 484-863-4561

CONSENT TO TREATMENT, RECORD RELEASE INFORMATION & PAYMENT AUTHORIZATION FORM

Adolescent therapy client, your Rights:

A. Voluntary: Treatment is provided on a voluntary basis through an **INDEPENDENT** company MindfulKids Services, LLC.

B. Confidentiality: Information discussed during the evaluation and treatment sessions is not released to anyone outside the session without your permission, except in the following cases:
- Suspected child abuse or neglect
- Threats to commit or admissions of committing crimes
- Suspected danger to self or others
- Supervision of our providers
- Continuity of care if you are hospitalized for a mental health reason

a. **What happens if your provider must break confidentiality?** If confidentiality must be broken, the provider will release the minimum amount of information necessary and will usually try to get your consent before the disclosure. The provider may contact: another healthcare provider, Special Needs Coordinator, Child Protective Services or law enforcement in the case of suspected child abuse or neglect, and the Family Advocacy Program. You can obt ain more information regarding patient confidentiality and the Health Information Portability and Accountability Act (HIPAA) by discussing this with the mental health provider or the HIPAA representative.

C. Privacy: Electronic copies of your treatment records are secured with a specialty health program (Therapy Notes)

PARENT, your Responsibilities:

A. Be actively involved in treatment. As a family we will discuss treatment goals. Treatment will be more effective if you take an active part in setting goals and deciding on treatment options, and talk to the provider if you have any questions about your child's status and your OWN need of support.

B. Keep all appointments and your contact information up-to-date. We utilize an automated appointment reminder system to help you remember appointments.

D. Face-to-face treatment is always preferred, but is not always possible, Telephone consultations are intended to assist in, not replace, the psychotherapy treatment. Please be aware that this choice will have an out of pocket fee associated to it ($100 per 60 min). We ask that you do not communicate with your provider by e-mail.

Please read and initial by each statement and sign at the bottom:

_____ I have read and understand the information in this form including my rights and responsibilities.

_____ I understand that treatment is voluntary.

_____ _____

Parent/Caregiver's Name & Signature / Date Patient's Name & Signature, Date

Christine Gorigoitia, Psy.D.

Provider's Name & Signature (CGW.), Date

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

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HIPAA PRIVACY AUTHORIZATION FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1a. I authorize MindfulKids, LLC to use and disclose the protected health information described below to _____ (provider or relative seeking the information, please provide FULL NAME & phone number).

This authorization for release of information covers the period of healthcare from:

a. _____ to _____ b. ☐ all past, present, and future periods.

1b. I authorize the release of my complete health record (records relatingto my healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

I authorize the release of my complete health record with the exception of the **following** information:

☐ **Mental health records** ☐ **Communicable diseases** (including HIV and AIDS)

☐ **Alcohol / drug abuse treatment** ☐ **Other** (please specify): _____

4.This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5.This authorization shall be in force and effect until termination of treatment, at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and th insurer has a legal right to contest a claim.

7. I understand that my treatment,payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

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Summary of Understanding:
CONSENT TO TREATMENT, HIPAA Privacy Authorization Form & Payment agreement.

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient.

_____

Date

Explanation of billing structure

In order to ensure that the therapy sessions with your child are efficient and not disrupted by administrative tasks, MindfulKids Services requests that you please collaborate by providing the following documentation one week prior to the first session:

[ ] Primary insurance and in-network secondary insurance cards must be submitted. Please contact both your primary and secondary insurance products to see if Mindfulkids Services is an in-network provider.

[ ] Credit card information. Credit cards are bill through a secure, third party institution and no credit card information is held directly by MindfulKids Services. Co-pays, deductibles and payments for out-of-network secondary insurance will be billed directly to your stored credit card. Receipts are available upon request to seek reimbursement from out-of-network secondary insurance products.

PAYMENT AUTHORIZATION

I hereby authorize my medical insurance to make payment directly to MindfulKids Services, LLC. I hereby affirm that all payments made directly to me for services provided by MindfulKids Services, LLC will be forwarded to their office upon receipt. Any additional fees including but not limited to phone consultations, and administrative fees on an as needed basis will be billed directly to me.

I understand I am financially responsible for all charges not covered by my insurance carrier for the care and treatment of my child.

_____ Signature of Parent/Guardian of Minor Child

_____ Please print name & YOUR DOB