EMERGENCY INFORMATION

(to be completed by client, parent, guardian)

Client Name

Date of Birth

Phone Number

Street Address

City

State

Zip

Primary Care Taker Name and Address

Phone Number

School

Grade

EMERGENCY CONTACTS: (2 required for children other than parents - 1 for adults)

Emergency Contact # 1 : Name, Address, Phone # & Relationship

Emergency Contact # 2 : Name, Address, Phone # & Relationship

Primary Physician: Name and Address

Phone Number

Medications

Health Issues

Assigned Counselor

Date Opened

Revised 1/1/2013

CCYSB
Carroll County Youth Service Bureau

Brief Strategic Family Therapy
Agreement to Terms of Program

Brief Strategic Family Therapy (BSFT) is a short-term, problem-focused, evidenced-based model of counseling for children, adolescents and their families. The program targets children with conduct problems, problematic family relationships, substance abuse, oppositional defiant behavior, delinquency, aggressive & violent behavior, risky sexual behavior, and anti-social peer involvement. This model of therapy involves the entire family in counseling sessions and focuses on changing the way family members interact, so that positive relationships are strengthened and negative behaviors are reduced. BSFT is based on the assumption that the family is the most important and influential system in the lives of children, that each family is unique, and that the behavior of each member can be understood only by considering the family context in which it occurs. BSFT is a strategic approach that uses pragmatic, problem-focused, and planned interventions that improve relationships in the family and helps parents develop strong, consistent, and effective parenting skills. BSFT is a flexible approach that can be adapted to a broad range of family situations in a variety of settings.

As participants of the BSFT program, your family was screened for appropriateness so that full benefits of the model can be achieved by your family. Below are the criteria that families are screened for and that all participants are asked to adhere to:

1. BSFT serves youth from 6 to 18 years of age

2. The length of therapy is typically between 8 and 24 sessions

3. Family is able to commit to all family members being involved in therapy for the duration of treatment

4. When appropriate, sessions are videotaped for clinical supervision and ongoing counselor certification to maintain fidelity to the model

5. In the event that the identified client receives a Psychiatric Evaluation that results in medication management services, medication monitoring visits must occur during the day or at a time slot that doesn't interfere with prime BSFT openings. Families have the option of having medication monitoring transferred to their family physician or another Psychiatrist once BSFT is completed.

I have read the criteria for the BSFT program and have been given the opportunity to ask and have answered any questions I may have regarding the above information.

____
Signature of Parent / Guardian *Date*

____
Signature of BSFT Therapist *Date*

Carroll County Youth Service Bureau, Inc.

59 Kate Wagner Rd., Westminster, MD 21157

410.848.2500 1.888.588.8441

Date: ______________

Name of Physician ______________________________

Address of Physician ______________________________

____

____

Dear Dr. ______________________

Your patient, ________________________________ , D.O.B. __________ is currently receiving services with the Carroll County Youth Service Bureau. To provide ______________________________ with the most comprehensive quality of care, I am requesting that you either complete the following questions regarding his / her physical status or send me a copy of his / her most recent physical examination. Thank you in advance for your cooperation.

Sincerely,

Dr. Judith Milliken
Medical Director

Information Below To Be Filled Out By Physician's Office Only

Date of Last Physical ____________________ If applicable, please provide growth chart

Are immunizations up-to-date ? ☐ Yes ☐ No ☐ n / a

Significant Findings ____

____

Current Medication ____

____

Does the patient have a history of : Allergies ☐ Yes ☐ No Neurological Disorders ☐ Yes ☐ No

Communicable Diseases ☐ Yes ☐ No

Any chronic long term illness ____

Any additional information that would be relevant to treatment ______________________________

____

____

Name of person & position filling out forms: ______________________________

Doctor's Signature ______________________________

THIS FORM MAY BE FAXED TO SUSAN GRAEFE (443) 244 -8879

I give permission to Dr. ______________________________ to release relevant medical information about

______________________________ to the Carroll County Youth Service Bureau.

______________________________ ______________________________ ______________

Patient / Parent Guardian Signature Witness Signature Date

Revised 12/28/2009

CARROLL COUNTY YOUTH SERVICE BUREAU, INC.

59 Kate Wagner Rd., Westminster, MD 21157

410.848.2500 1.888.588.8441 410.876.3016 (Fax)

CONSENT FOR THE USE OF RECORDING MEDIA* IN COUNSELING SESSIONS

I, ______________________ parent or guardian of ______________________, ☐ authorize ☐ prohibit

______________________ to record* sessions with my ☐ Self ☐ Family ☐ Child

Counselor's Name

(check all that apply)

I understand the purpose of media recordings is for the supervision of counseling sessions. I also understand the media will be held in the strictest confidence with the Carroll County Youth Service Bureau Supervision, and will be erased at conclusion of each supervision session.

This permission expires: End of Treatment

____

Signature of client, parent, guardian, authorized representative — Date

* Recording media includes, but is not limited to, the use of audiotape recorders, videotape recorders, digital technology, or "live" sessions. "Live" sessions include therapists in supervisory roles watching the session in "real time".

CARROLL COUNTY YOUTH SERVICE BUREAU, INC.

59 Kate Wagner Rd., Westminster, MD 21157

410.848.2500 1.888.588.8441 410.876.3016 (Fax)

BSFT: STATEMENT OF CONFIDENTIALITY OF CLIENT RECORDS and CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Carroll County Youth Service Bureau adheres to all laws and regulations regarding the confidentiality of client information. The confidentiality of clients' records is protected by State and Federal law and regulations. No information regarding the treatment of any Carroll County Youth Service Bureau's clients shall be disclosed to any non-Bureau person or agency without the express written consent of the client. Even with a written release, disclosure of client information by Carroll County Youth Service Bureau shall be limited to the minimum of identifiable information necessary for the intended purpose of its release.

However, client authorizations are not required under the following circumstances:

1. Medical and / or psychiatric emergencies
2. Suspected child abuse and neglect
3. Threats to physically harm self or another person
4. Disclosure required by law
5. Disclosure required by insurance companies for reimbursement
6. Disclosure of sexual abuse
7. In some cases, limited information may be shared where custody agreements are in place.

Law and regulations require the reporting of:

1. Suspected child abuse or neglect to appropriate state and local authorities.
2. Threats to physically injure another person to that person.

I, ______________________, have read and understand my and my family's rights. I have also received a copy of this notification.

Client Date Witness Date

Parent / Guardian Date

The Institute for Innovation and Implementation on behalf of Maryland's Children's Cabinet will collect BSFT client information related to demographic characteristics, length of services, BSFT assessment data and discharge outcomes for the purposes of monitoring BSFT program effectiveness. In addition, The Institute will collect names, dates of birth and State agency IDs (i.e., Medicaid numbers) for the purposes of monitoring long term outcomes through State Agency data systems (i.e., are youth living with family, going to school and have they had no new arrests post treatment). The Institute is the party responsible for protecting the confidentiality of this personal information and will follow all applicable laws and regulations relevant to the use and dissemination of BSFT client information released to the Institute. All identifying information such as names will be removed once youth are matched in State data systems. No identifying information of BSFT clients will be included in any reports produced by the Institute for Innovation and Implementation. All identifying information will be kept in secure databases that are password protected. Jennifer Mettrick, Evaluation Director, will be the individual at The Institute for Innovation and Implementation who will identify the persons with approval to access the information.

I consent to release information in the following way: (check one)

☐ ***With*** identifying information of Name and Medicaid Number

☐ ***Without*** identifying information of Name and Medicaid Number

Client Date Witness Date

Parent / Guardian Date

Carroll County Youth Service Bureau, Inc.
59 Kate Wagner Rd., Westminster, MD 21157
410.848.2500 1.888.588.8441 410.876.3016 (Fax)

Juvenile Consent to Receive Services

My Son / Daughter, ______________________________ has my permission to receive services from the Carroll County Youth Service Bureau (CCYSB).

Service Policies:

I have read and have been given copies of the following policies:

- Statement of Confidentiality of Client Records
- Grievance Policy and Procedures
- Consumer Responsibilities
- Discharge Policy
- Consumer Rights
- General Policy and Procedures

Follow-up Release Information:

To conduct follow-up studies only, I give permission to Carroll County Youth Service Bureau to request from the Department of Juvenile Services the status of involvement (if any) of my child with the DJS for two years following termination of services with CCYSB.

For the purpose of conducting follow-up evaluation studies of CCYSB, I give permission to CCYSB to release to the DJS, for up to two years following termination of services with CCYSB, the following information:

1. The full name of my child.
2. My child's date of birth

Any additional information is considered confidential and may only be used with my permission.

I have been given the opportunity to ask and have answered any questions I may have regarding the above policies.

______________________________ Date ______________________________ Date
Signature of Parent or Guardian Date Signature of Witness Date

Relationship (check one):

☐ Parent / Guardian ☐ Aunt / Uncle
☐ Grandparent ☐ Sibling

DHMH regulations stipulate that a copy of a court order and / or a custody agreement, for a juvenile who receives services from an Outpatient Mental Health Clinic, be received by the provider for placement in the juvenile's file. (COMAR 10.21.17.07.D.2.j)

Court Order ☐ does ☐ does not exist for ______________________________
Client Name

Agency / Individual Court Order requested from: ______________________________

Date requested: ______________ Manner of Request ☐ Letter ☐ Telephone ☐ In Person

Result of Request:

Copy of Court Order received ☐ Yes ☐ No Date: ______________

Custody agreement ☐ does ☐ does not exist for ______________________________
Client Name

Agency / Individual Custody agreement requested from: ______________________________

Date requested: ______________ Manner of Request ☐ Letter ☐ Telephone ☐ In Person

Result of Request:

Copy of Custody agreement received ☐ Yes ☐ No Date: ______________

CARROLL COUNTY YOUTH SERVICE BUREAU, INC.
59 Kate Wagner Rd., Westminster, MD 21157
410.848.2500 1.888.588.8441 410.876.3016 (Fax)

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Client Name [ ]

Signature

Date

In case the Client is a minor print:

Personal Representatives Name: [ ]

Signature

Date

Relationship (check one): ☐ Parent / Guardian ☐ Grandparent ☐ Aunt / Uncle ☐ Sibling

Agency Representative

Date