



# Denali Family Services, Informed Consent for Treatment

I, \_\_\_\_\_ or; \_\_\_\_\_  
(print name of client) (print name of parent/ guardian)

request and consent to receive mental health treatment for \_\_\_\_\_  
(client name)  
from Denali Family Services and its mental health staff members.

\_\_\_\_ Such services may include diagnostic procedures, mental health assessments, and treatment planning. The latter may include transportation by staff, play therapy, individual and group skills development training, individual and group psychotherapy, family therapy and family skills development training, and other activities identified by the treatment team on the master service plan. *Denali Family Services does not conduct experimental or nonstandard treatments.*

## Receipt of Consumer Rights Handbook

\_\_\_\_ I have received a copy of Denali Family Services Consumer Rights Handbook. The handbook has been reviewed with me and I understand my rights and responsibilities as a consumer. I understand how to use the grievance process if I am not satisfied with services.

## Receipt of Notice of Privacy Practices

\_\_\_\_ I have I received a copy of Denali Family Service's Notice of Privacy Practices.

## Confidentiality

\_\_\_\_ Denali Family Services respects your right to privacy. In some instances, however, mental health professionals are bound by law to report to appropriate medical and law enforcement personnel when you are at risk of harm to self or others or if it is suspected that a child has been abused or neglected. Confidentiality can be broken if the agency is ordered by a law enforcement officer or court to disclose information. See Denali Family Services Privacy Practices for more information.

## Parent/Guardian Participation

\_\_\_\_ The support and cooperation of parents/guardians with the Denali Family Services Treatment Program is essential for effective treatment. Parents/Guardians, being a crucial part of treatment, will be expected to participate in the various treatment activities assigned to them to the fullest of their ability and within geographical limitations. Regularly required participation includes:

1. Participation in treatment plan development, treatment plan reviews and continuing care planning;
2. Attendance at Individual and Family Therapy sessions;
3. Participation in Family Skill Development sessions with the Case Managers; and
4. Follow through with developing positive social supports.

\_\_\_\_ As the legal guardian of the client, I agree to participate in the above treatment activities to the fullest of my abilities.

## Missed Appointments

\_\_\_\_\_ It is the client's responsibility to arrive to appointments on time, or cancel and reschedule at least 24 hours in advance if unable to come to an appointment. Appointments include: any appointment with a psychiatrist or doctor, individual, family or group therapy appointments, home visits, and treatment team meetings. When a client misses an appointment the assigned clinician will attempt to contact the client or, if a minor, the client's parents/foster parents by telephone. If the client misses a second appointment in a 30 day period, the clinician will initiate an agency form letter giving the option to reschedule to a non preferred time between 9 am and 2 pm or to discharge from services for a minimum period of 90 days. Any additional no shows will result in a discharge from services. If the client is receiving therapeutic foster care, skill development services in school/after school or case management services Denali Family Services will provide 2 weeks of continued services and will work with the client/client's family to make appropriate discharge arrangements. If the client is court ordered or in state's custody, notification will be made to the legal guardian/court as applicable, and the client regarding the client's failure to attend appointments. If the client does not respond in two weeks, as stipulated in the letter, the client will be discharged.

## Transportation

\_\_\_\_\_ At Denali Family Services (DFS) we believe clients/ families should be as independent as possible. Clients/ families are encouraged to develop their own permanent resources, such as family members/ friends and other natural supports as much as possible. Relying on DFS for transportation needs can prevent some families from becoming independent.

DFS recognizes some clients/ families will have transportation needs and may need DFS to temporarily assist with some of these needs. Whenever possible, DFS will assist by helping find appropriate resources. DFS staff can assist clients/ families in understanding the public transportation system works. This can include providing information on the schedule/ how to specifically get from one place to another, riding the bus with a client/ family on a few occasions, or referring the client/ family to a service which can teach these skills.

DFS will provide transportation when it is determined that this transportation is *medically necessary*. The need for transportation will be reviewed at least once every three months. The goal is to find ways to help clients/ families meet their own transportation needs.

DFS will determine if a client/ family meets criteria for *medical necessity* transportation by using the factors listed below.

- Client/ family with a single working parent and works during the time when appointments are available Arrangements to change work hours or gain time off are not possible with current employment.
- The client/ family with no vehicle and utilizing public transportation to attend appointments would place an undue hardship on the family. (For example: A single parent transporting several young children on the bus to an appointment when there are no other family/ resources to provide day care for the children.)
- Inability to use public transportation due to the level of disability of the client/ family member or because of safety issues.
- In cases where the client/ families mental health issues are severe enough to interfere with the ability to utilize community resources such as public transportation.

## Consent to Participate in Therapeutic Activities

\_\_\_\_\_ I authorize *Denali Family Services* and its representatives to include (child's name) \_\_\_\_\_ in therapeutic activities that include teaching living skills, social and communication skills, and other needed life skills for adapting to one's home, school, and community.

\_\_\_\_\_ *Denali Family Services* involves young people in activities in a variety of outdoor settings, and in all kinds of weather conditions. Safety is our primary concern, but active young people will, on occasion, find ways to injure themselves. Are there activities that your child should not participate in due to health concerns or parental desires?  
No  Yes  Please provide description: \_\_\_\_\_

\_\_\_\_\_ My son/daughter/ward has permission to participate in all *Denali Family Services* activities, except as noted by me. I recognize that my child will be participating in active, outdoor programs with other children and that accidental injuries or illness may result. I assume the inherent risks of the program and authorize my child's participation. Children will walk or be transported by *Denali Family Services*' vans or staff members' vehicles to both urban and wild areas around the Anchorage Bowl. Vehicles operated by *Denali Family Services* are equipped with seat belts which participants are required to wear. I authorize *Denali Family Services*' staff members to transport my child in the manner described.

\_\_\_\_\_ I give permission to *Denali Family Services* to provide my son/daughter/ward with transportation in agency vehicles and in personal staff vehicles for the purpose of, but not limited to, transport to and from the agency/program, field trips, and individual community outings. I understand that the agency and all staff are required to have adequate auto insurance at all times.

\_\_\_\_\_ No guarantees have been made to me concerning the care rendered by Denali Family Services under this Informed Consent for Treatment. Denali Family Services have provided me a full explanation of the procedures and benefits of each applicable service.

\_\_\_\_\_ I agree to release Denali Family Services, its directors, officers, employees, and agents from liability for personal injury and damages resulting from the activities to which I have hereby consented. A photocopy of this consent form shall be as valid as the original.

\_\_\_\_\_

Client or Guardian

\_\_\_\_\_

Date

\_\_\_\_\_

Relationship to Consumer

\_\_\_\_\_

Witness

\_\_\_\_\_

Date

## **Grievance Policy and Procedure**

\_\_\_\_\_ It is a policy of Denali Family Services that all of our clients will be treated with respect, dignity, and equality. If you feel your rights as a client have been violated in any way, we ask that you send a written statement to the Utilization Review Coordinator.

### Procedure

1. All clients have the right to file a grievance without fear or intimidation, or retaliation of any kind.
2. All clients shall be notified in writing of the grievance policy, during the intake process. A signed copy of receipt of the grievance policy shall be maintained in the client record, and updated at least annually.
3. Client grievances and feedback can be filed in one of three ways:
  - a. any staff person shall provide a feedback form to any consumer upon request. Forms shall be readily available.
  - b. a consumer may file a verbal complaint directly or over the phone with the utilization review coordinator who will complete the consumer feedback form.
  - c. clients can file a grievance by e-mail to the utilization review coordinator.
  - d. clients can also file a grievance by going to Denali Family Services web site at [denalifs.org](http://denalifs.org) and selecting the how to file a grievance link.
4. If clients would like assistance in filing a grievance the client can designate a representative or advocate to assist them with all steps of the grievance process.
5. Upon request a clients case manager or clinician or the utilization review coordinator can assist the client in filing a grievance or provide a written referral to a client organization such as NAMI-Alaska or the Disability Law Center to assist them with a grievance.
6. The utilization review coordinator shall acknowledge positive feedback verbally or in writing to the consumer.

7. If the feedback is negative, the utilization review coordinator shall attempt to resolve the issue with the client in collaboration with the clinical director and treatment team within five (5) business days of receiving the initial grievance.
8. If the client does not feel that the issue was satisfactorily resolved, s/he must inform the utilization review coordinator within ten (10) business days.
9. Within five (5) business days of receipt of notice of consumer appeal, the CEO shall review all related documentation and make a determination. The CEO shall send notice of this determination to the consumer and to the utilization review coordinator.
10. If the client wishes to appeal the decision further, they may request verbally or in writing to have the appeal forwarded to the board of directors to be reviewed at the next board meeting.
11. Within 30 business days if a satisfactory resolution can not be found a referral to Behavioral Health will be made to provide technical assistance for an unresolved grievance.
12. If the grievance involves alleged abuse, alleged unnecessary seclusion or restraint it will automatically be brought to the board of directors at the next board meeting.
13. The utilization review coordinator shall implement the resolution through collaboration with appropriate personnel, and shall document the resulting plan for grievance resolution.
14. The utilization review coordinator shall maintain a copy of the complaint, the resolution, and the notification.
15. The utilization review coordinator shall maintain a cumulative list regarding the nature and resolution of complaints. This list will include the type of incident/ concern and the resolution but the names of the clients and involved staff members would remain confidential.
16. The board of directors review a report analysis of client complaints at least once per quarter to assess complaint patterns, liability issues, and potential areas for improvement.
17. The continuous quality improvement process shall include review of feedback forms.
18. Client confidentiality shall be maintained throughout the grievance procedures.

## **Employee Responsibilities to the Client**

\_\_\_\_\_ I understand the employee responsibilities to the client listed below:

1. Provide full information before and during service, and honestly answer consumer questions about:
  - Similar services in the community;
  - How soon services can be provided and alternatives if service is delayed, including a referral to another service provider;
  - Payment rates and options including insurance reimbursement;
  - Diagnosis and recommended treatment including medication and special treatment procedures, medically prescribed diet, limitation of right to self-determination, degree of risk; and alternatives to treatment and their consequences;
  - The consumer's medical record, including providing a copy if requested in writing;
2. Provide service without discrimination, but with regard to ethnic and cultural characteristics that effect the therapeutic relationship;
3. Keep information about the consumer confidential within the law. In some instances, the mental health professional is bound by law to report to appropriate medical and law enforcement personnel when you are at risk of harm to self or others or if it suspected that a child has been abused or neglected. The only other time confidentiality can be broken is if the agency is ordered by law enforcement officer or court to disclose information;
4. Fully include the client as an active participant in developing and modifying treatment goals and methods;
5. Provide for communication between a client and significant others in an emergency;
6. Explain the consequences of a client's refusal of treatment and offer alternatives;
7. Respect a client's right to refuse treatment unless limited by law of court order;
8. Respectfully address a client grievance in accordance with the client grievance policy;
9. Respect the right to privacy, including seeking prior approval from a client to participate in public display; and
10. Freedom from restraint unless a client presents a danger to him/herself or others.

## Indian Child Welfare Act Acknowledgment

\_\_\_\_\_ The Indian Child Welfare Act (ICWA) is mandated by the Federal Government and requires all workers to be aware of the cultural background of consumers. You should know which tribe all Alaska Native children and Indian children are from, and are required to work with the Tribe in making sure the needs of this child are met, especially in regards to out of home placements. The Tribe is to be consulted to see if there are possible placement options within the child's Tribe that can meet their needs.

1. Is the client of Indian or Alaska Native descent? Yes  Tribe: \_\_\_\_\_ No  If yes, answer 2-4
  
2. Has the parent and/ or Tribal Representative been notified if the client is in custody? Yes  No
  
3. What efforts have been made to work with the client's Tribe in regards to out of home placement?  
\_\_\_\_\_  
\_\_\_\_\_
  
4. Has the client been placed according to preference to ICWA? Yes  No  \_\_\_\_\_  
\_\_\_\_\_

### **This section is applicable only for clients involved in Child in Need of Aid proceedings:**

I am a child, or the guardian ad litem of a child, involved in Child in Need of Aid (CINA) proceedings. The protections and privileges of CINA Rule 9 have been explained to me and I have had the opportunity to consult with my guardian ad litem or attorney if applicable. As part of my treatment, I am choosing to waive the privileges provided by CINA Rule 9 with regards to all members of my treatment team including, but not limited to, family members. I understand that I can claim the privilege at any time by notifying a member of the Denali staff or my guardian ad litem.

Client	Date
Guardian Ad Litem/Attorney	Date
Witness	Date

### **Contact Information for Parent/Legal Guardian and Other Authorized Persons**

Parent/Guardian 1	_____
Home Address	_____
Home Phone	_____
Business Address	_____
Business Phone	_____
Parent/Guardian 2	_____
Home Address	_____
Home Phone	_____
Business Address	_____
Business Phone	_____

**Other contacts:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

**Authorized for the Following (please mark):**

- Pick up the child from DFS
- DFS staff drop the child off with
- Contacted in case of an emergency
  
- Pick up the child from DFS
- DFS staff drop the child off with
- Contacted in case of an emergency

## Insurance Authorization and Assignment

\_\_\_\_ All professional services rendered are charged to the patient. The client (if own guardian), guardian, and/or parent is responsible for all fees, regardless of private or group insurance coverage. Your insurance company will be billed as a courtesy. However, you are responsible for your bill. **Your co-payment is expected at the time of your visit.** If reimbursement rate or deductible is unknown at the time of your visit, a 50% payment will be required.

\_\_\_\_ I hereby authorize Denali Family Services to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the therapist(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

\_\_ As client or legal guardian I am fully and solely responsible for all payments for services rendered in accordance with this Informed Consent for Treatment.

### Client Information

Client name:	Social security #:
Address:	Date of birth:
City:                      Zip code:	Sex: male <input type="checkbox"/> female <input type="checkbox"/>
Home phone:	Work phone:

### Responsible Party Information

self    spouse    parent    foster parent    OCS    other

Responsible party name:	Social security #:
Address:	Date of birth:
City:                      Zip code:	Sex: male <input type="checkbox"/> female <input type="checkbox"/>
Home phone:	Work phone:

### Primary Insurance/Billing Information

The insured person is:  self    spouse    parent    other

Insurance company name:	Social security #:
Policy holder:	Date of birth:
Address:	Sex: male <input type="checkbox"/> female <input type="checkbox"/>
City:	Medicaid/insurance ID #:
State:                      Zip code:	Insurance group #:
Work phone:	Insurance company phone #:

Is the client covered by any other insurance?    yes                       no

### Secondary Insurance/Billing Information

The insured person is:  spouse    parent    other

Insurance company name:	Social security #:
Policy holder:	Date of birth:
Address:	Sex: male <input type="checkbox"/> female <input type="checkbox"/>
City:	Medicaid/insurance ID #:
State:                      Zip code:	Insurance group #:
Work phone:	Insurance company phone #:

\_\_\_\_\_  
Client or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Affidavit of Custody**

**Date:** \_\_\_\_\_

**Client Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

I, hereby affirm that:

The referenced child is in the custody of the State of Alaska and that a verification of State Custody is in process and a copy thereof will be provided to Denali Family Services as soon as it is available. I also state that I am a legal representative of the Office of Children’s Services/Division of Juvenile Justice of the State of Alaska. This Affidavit of Custody is current until: \_\_\_\_\_

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

I am the legal guardian of and have legal authority to admit the referenced child to Denali Family Services.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Print Name*

- I am *not* the parent of this child, but have been appointed legal guardianship.  
(Provide proof of court hearing confirming guardianship)
- I am the parent of this child and have sole legal custody of this child.  
(Provide proof of court hearing confirming this sole custody and birth certificate of child)

I verify that on this day appropriate documentation was give to verify the above information.

\_\_\_\_\_  
*Notary Public*

\_\_\_\_\_  
*My Office Expires*

**Consent for Required Medical/Dental/Vision Care and Emergency Services**

I (parent, legal guardian/legal custodian) \_\_\_\_\_, authorize and hereby give consent to Denali Family Services to provide or cause to be provided emergency and/or ordinary required medical/dental/vision care and treatment for (client’s name) \_\_\_\_\_.

**Medical care and treatment, within the acceptable standard of General Practice, may include, but is not limited to (please initial):**

- \_\_\_\_\_ Evaluation and treatment of colds, sore throats, bronchitis, gastroenteritis, urinary tract infections, and vaginal infections.
- \_\_\_\_\_ The evaluation and treatment of abdominal pain, chest pain, headaches or other pain symptoms.
- \_\_\_\_\_ Evaluation and treatment of common skin disorders including, but not limited to: acne, athlete’s foot, and common skin rashes.
- \_\_\_\_\_ Evaluation and treatment to common injuries including, but not limited to sprains, strains, abrasions and/or possible fractures.
- \_\_\_\_\_ Routine physicals and immunizations.
- \_\_\_\_\_ Pregnancy testing for females who are in the menarche stage of development.
- \_\_\_\_\_ Blood and/or urine testing.

Consent may include, but is not limited: Administration of necessary medications including antibiotics, injections of medication, x-rays, and necessary anesthetics, testing as determined by the attending physician.

**A specific written, dated and signed consent will be obtained for all surgical procedures except in an emergency situation. In an emergency situation, consent is given from transfusions or whatever operations, testing or medical procedures that may be deemed necessary (please initial).**

- \_\_\_\_\_ Dental care, within the acceptable standard of Dentistry, may include, but is not limited to, annual dental examinations and cleaning, filling, crowns or extractions, or as needed.
- \_\_\_\_\_ Vision care, within the acceptable standard of Optometry, may include, but is not limited to, yearly vision examinations when the student has prescription eyeglasses and/or contact lenses, or as needed.
- \_\_\_\_\_ Both ordinary and emergency medical, dental, vision care and treatment will be provided by individuals who are duly licensed as required by law.
- \_\_\_\_\_ Only emergency medical, dental, vision care and treatment will be provided by individuals who are duly licensed as required by law.

**Consent for Emergency Medical or Surgical Care Only (please initial)**

\_\_\_\_\_ This authorizes *Denali Family Services* personnel to give permission to appropriate medical or hospital personnel to provide emergency medical or surgical care for (client’s name) \_\_\_\_\_ in the event that I cannot be contacted immediately. It is understood that a conscientious effort will be make to locate me or my child’s other parent or legal guardian. I understand my obligation to keep *Denali Family Services* informed of my whereabouts. I will assume the cost of necessary medical or surgical care.

\_\_\_\_\_ I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, and is given to provide Denali Family Services with the authority to consent thereto, as my/our agent, in the exercise of Denali Family Services best judgment.

\_\_\_\_\_ Expenses for medical/dental/vision care and treatment should be billed to whatever private insurance the parent and/or guardian may have, and to Medicaid, if appropriate. Any medical/dental/vision expenses that are denied by Medicaid are the responsibility of the placing party and/or the State of Alaska.

This consent is valid for duration of placement at Denali Family Services.

\_\_\_\_\_  
Parent/Guardian/Legal Custodian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Current Medications**

Medication type(s): \_\_\_\_\_

Dosage prescribed: \_\_\_\_\_

Time of day for each dose: \_\_\_\_\_

**Authorization For Administration of Medication**

\_\_\_\_ I authorize the administration of (medication, vitamins, minerals, supplements, etc.) \_\_\_\_\_  
which I have provided to Denali Family Services (child's name) \_\_\_\_\_.

**Any known Allergies or Medical Conditions?** Yes  No

If yes, please list allergies and/or describe medical condition(s):

\_\_\_\_\_

\_\_\_\_\_

: