Welcome to Play Therapy House!

Please look over the information in the following packet carefully. To begin the counseling process with us, complete and sign all paperwork enclosed and return to Play Therapy House via one of the options listed below:

a. Email to your counselor:
   Jackie– jackie@playtherapyhouse.com
   Kailee– kailee@playtherapyhouse.com
b. Fax to 208-639-9957
c. Mail/In Person to 2577 S. Five Mile Rd., Boise, Idaho 83709

You may also bring the completed packet to your first intake session if it is more convenient for you. If you have any questions, please feel free to ask your therapist for an explanation at your first appointment, or call us at any time at 208-639-1897. We look forward to working with you and your child!

Before Your First Appointment…

Please use the checklist below to make sure you are ready for your first appointment. Please do not hesitate to reach out with any questions about the requirements listed below.

Please complete the documents listed here prior to your child's first appointment:

- ➔ ___ The following forms must be fully completed and signed by a parent or legal guardian. Any consents or releases of information (ROI) **must also be signed by any client who is over the age of 14.**
  - ◆ Client Demographics
  - ◆ Informed Consent
  - ◆ Notice of Privacy Policies (HIPAA)
  - ◆ Comprehensive Diagnostic Assessment (Intake Form)
  - ◆ Wellness Assessment Form (if covered by Idaho Medicaid)
  - ◆ ICAN's Form (if covered by Idaho Medicaid)
- ➔ ___ Fill out a release of information form (ROI) for your primary care doctor.
- ➔ ___ Fill out a release of information form (ROI) for any caregiver that might bring the child to appointments (ex. stepparent, grandparent, etc.)
- ➔ ___ Fill out a release of information for any other entity involved in the child's treatment (ex. school counselor, psychologist, etc.)
- ➔ ___ Bring a copy of any divorce decrees, custody paperwork, or guardianship documentation.
- ➔ ___ Bring a copy of your insurance cards to your first appointment.

*****PLEASE NOTE*****

We require that a parent or caregiver is present on property for the duration of the appointment for all appointments until a client is 14 years of age or older. If a parent or legal guardian is unable to be present for an appointment, we MUST have a release of information form for the caregiver bringing the child and it MUST be completed and signed by the parent or legal guardian. Extra release forms are available on our website.

If a parent or legal guardian is not present and we do not have a release form on file for the person bringing the child, the appointment will be rescheduled.

Play Therapy House, inc.

Client Demographics

Child's Name: _____ Age: _____ DOB: _____

Child's SSN: _____ Gender: _____

Child's Address: _____ City: _____ State: _____ Zip: _____

Current School: _____ Grade: _____

Physician: _____ Physician's Phone: _____

Emergency Contact Name: _____ Phone Number: _____

We are required by Federal health care programs to request this information as a part of the demographic data they collect. Individuals are asked to indicate one or more races and ethnicity that apply from among the following or you may decline to specify.

Ethnicity: ☐ Decline ☐ Hispanic ☐ Latino ☐ Not Hispanic or Latino

Race: ☐ Decline ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Parent/Guardian Information

Parent/Guardian Name: _____ Age: _____ DOB: _____

Phone Number: _____ E-mail: _____

Employer: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance Name: _____

Subscriber Name: _____ DOB: _____

Group Number: _____ ID Number: _____

Secondary Insurance Name: _____

Subscriber Name: _____ DOB:_____

Group Number: _____ ID Number: _____

PERMISSION TO RELEASE: I hereby authorize Play Therapy House, Inc. to release any medical information necessary to process claims and to apply for benefits on my behalf for covered services furnished to me by Play Therapy House, Inc. I certify that the insurance information supplied is correct and understand I will be responsible for any services not covered by insurance. I also understand that I am responsible for any co-pay I have with my insurance plan.

Parent/Guardian Signature: Date:

Custody Information

- ❏ Full Legal Custody? Please explain: _____
- ❏ Joint legal custody? Please explain: _____
- ❏ Protection order related to any family member? Please explain:_____
- ❏ Contact Information for Parent/Guardian 2 (if applicable):

  Name: _____

  Phone: _____

  Email: _____

❏ Copy of divorce decree or custody paperwork provided?

RELEASE OF INFORMATION
I understand that: ○ Once Play Therapy House, Inc. discloses my health information by my request, it cannot guarantee that the Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information. ○ I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524) ○ My records are protected and cannot be disclosed without written permission ○ This authorization will remain in effect until written notice of revocation to Play Therapy House, Inc. is received.
Signature of Client or Legal Guardian:
Date:

Play Therapy House, inc.

Informed Consent

Welcome to Play Therapy House, Inc. We appreciate you giving us the opportunity to help your child and family grow, connect, and heal. This form will help provide necessary information for the counseling process and lay out your rights and responsibilities as a client. It is important that you know how we will work together.

Approach to Therapy and Client Involvement

Counselors at Play Therapy House, Inc. may utilize a variety of treatment modalities based on the individual needs of each client. Our therapists specialize in the use of child-centered play therapy, and may also include cognitive behavioral, gestalt, reality, and solution-focused techniques in your child's treatment. Your child's therapist will meet with you individually to ensure that you understand the therapeutic process and treatment techniques used in therapy. It is important that parents/caregivers take an active role in the counseling process, and feel comfortable sharing thoughts and feelings about the fit of therapy. If you have any concerns about this being the correct treatment option for your child, we are more than happy to discuss referral options or other treatments that may be of help to your family. Play Therapy House, Inc. does not provide crisis counseling services. If a crisis arises during the course of treatment, please call 911 or go to your nearest emergency room.

If parents share joint legal custody of a minor under the age of 14, both parents are entitled to disclosures about the therapeutic process including information about goals, progress, and themes in therapy. It is the responsibility of the parent who requested therapy to inform the other parent that their child is in therapy and they are entitled to the same disclosures about the therapeutic process. Please provide a copy of your divorce decree or custody arrangements to your therapist during intake. **If your divorce decree specifies that consent from both parents is required to begin treatment, we cannot begin therapy until both parents provide written consent.** If at any time one parent revokes consent to therapy, treatment will be stopped until the parents have reached an agreement or can provide legal documentation allowing the consent of only one parent/guardian.

Minors over the age of 14 are allowed to seek counseling services without the consent of a parent. When a minor over the age of 14 is being treated, the therapist and child will work together to determine how much information will be shared with parents.

Limits of Confidentiality

Confidentiality in the counseling relationship is an important aspect of building trust and rapport. Confidentiality includes not only what is said in the counseling session, but also physical documents such as artwork or any photography of artwork in the clinical file. Parents have the right to discuss general information such as themes, progress, and goals within therapy. Information pertaining to the child or his/her record will not be released to anyone other than a custodial parent without

signed release of information. In cases of joint legal custody, both parents are entitled to information and are invited to participate in the therapeutic process.

In accordance with HIPAA regulations, parents have the right to request access to their child's mental health records. It is our policy to provide a summary of a file in lieu of a full file release whenever possible. We do not release files or components of files to any third parties. It is our responsibility to protect the confidentiality of therapy for every client, and your counselor will go over the risks and benefits of releasing information with you should you require access to your child's file. **If at any point in time litigation related to your child develops, files will ONLY be released in response to a valid court order issued and signed by a judge.**

State and federal laws mandate that confidentiality is protected except in the cases of:

- **Threat of harm to self/others**
- **Evidence of abuse/neglect to a child or vulnerable adult**
- **Law enforcement officials in emergency situations**
- **Records subpoenaed by a judge**

Confidential or sensitive information is not appropriate to be discussed in the lobby. If you would like to discuss your child's therapy, please schedule a parent consultation with your therapist. From time to time, your therapist may consult with other counselors on staff, supervisors, or in educational settings regarding your child. During consultation, identifying details will be kept to an absolute minimum. The purpose of consultation is to ensure that your counselor is providing the most appropriate and effective treatment at all times. Please review the HIPAA practices included in this packet that detail exactly how your child's information will be used and released.

Privacy

Your counselor will not approach you if you happen to see each other in public. If you or your child choose to approach your counselor, they will act with discretion in order to protect confidentiality.

If you encounter your counselor on social media, please know that they are ethically bound to not respond to any "friend requests," messages, or other attempts to contact them through these non-secure avenues. None of your child's information, artwork, or progress will be shared on Play Therapy House, Inc. social media, including Facebook, Instagram, Pinterest, etc. Please keep in mind that posting to social media while in our lobby may identify you as a client at Play Therapy House, Inc. Additionally, posting to our social media pages will allow others to identify you as a client utilizing our services. We also cannot guarantee confidentiality through e-mail.

Idaho administrative code requires us to inform you that sexual relationships with clients or their parents are never appropriate and must be reported to the board.

Telehealth Policies

From time to time, we may utilize telehealth services to meet with you to discuss your child's progress in therapy. Telehealth has a unique set of benefits and risks that you should be aware of. Benefits of these services include convenience, scheduling, and decreased barriers to accessing mental health care. Potential risks include limited research around effectiveness, possible security and confidentiality implications, and technology failures. While most insurance companies cover telehealth services, payment is not guaranteed. Please check with your insurance company prior to scheduling a telehealth appointment to ensure that this is a covered service. If telehealth is determined to be the best method of communicating with you about your child, your counselor will help you to gain access to our secure client platform. Telephone consultations are also considered telehealth and may be billed to your insurance. At this time we do not offer Play Therapy sessions with children via telehealth.

Risks/Benefits of Therapy

Therapy has both benefits and risks. Benefits of therapy may include mood regulation, improved communication, improved functioning at home/school, and integration of difficult or troubling experiences.

We often tell parents that at first, it may seem as if things are getting worse before they get better. Within the first few sessions, you might see an increase in behaviors such as tantrums, emotional outbursts, sadness/crying, etc. If you notice these changes in your child, please communicate them with their counselor. If your child is close to termination of counseling, we recommend scheduling at least 3 final sessions to transition successfully out of the counseling relationship.

Appointments

We recommend that children attend therapy in comfortable clothing that may get messy occasionally. Art materials utilized will be chosen specifically for their ability to wash out of clothing easily. If your child is sick, please keep them home from therapy. Sick children are unable to fully engage in therapy, and it is required that you keep them home. There is never any penalty for canceling or rescheduling appointments at Play Therapy House due to illness.

Please inform your counselor if you are unable to attend a scheduled appointment. We require at least 24 hours notice for cancellations. If an appointment is canceled with less than 24 hours notice, it is considered a late cancellation. After 3 late cancellations, your child's appointment time will be forfeited and your clinician will work with you to offer another time or discuss the appropriateness of therapy at this time. If you do not attend a scheduled therapy appointment, your appointment time may be forfeited and your child's file closed. If you cannot attend your scheduled appointment, please inform your therapist in a timely manner.

If you arrive for your child's appointment more than 15 minutes late, the appointment will be rescheduled. We are unable to make therapeutic progress with limited session time, so it is important to work with your counselor to find a time that works well for your family each week.

Health Policy

In an effort to minimize the risk of the spread of infectious diseases between clients and staff, we require cancellation of appointments in the case of infectious illness. Staff members will notify supervisors of exposure to, or known infection with general communicable diseases (which include but are not limited to influenza, meningitis, mumps, whooping cough, measles, diphtheria, lice, chicken pox, and tuberculosis), and to see a medical provider to develop a plan which minimizes the risk to others becoming infected.

Employees and/or clients will be temporarily restricted from the office if infected with communicable respiratory illness or contagious illness. They will be allowed to return to the office after they have been cleared by a physician or have gone 24 hours without symptoms. When necessary, supervisors will communicate with public health officials regarding infectious disease exposure. You and/or your child are welcome to return to the office when you have been asymptomatic for 24 hours.

Insurance

Insurance carriers may be billed as a courtesy to you. If your policy requires a referral or prior-authorization, you will be solely responsible to have these items the day of your appointment. It is your responsibility to verify coverage and any co-payments or fees required prior to your first appointment. Play Therapy House, Inc. is not responsible for calling your insurance carrier to inquire about referrals, benefits, and/or co-pays. Please bring your insurance card to your first appointment so that we can make a copy. Play Therapy House, Inc. utilizes a third party billing company for all insurance claims. If your insurance company has not paid Play Therapy House, Inc. in a timely manner, you will be responsible for payment of all charges incurred.

If payment has not been made for 60 days and arrangements for payments have not been made, we have the option to pursue legal means to secure payment including utilizing a collections agency or going through small claims court. If such legal action is necessary, the cost will be included in the claim.

Play Therapy House, Inc. is a medicaid provider and bills for counseling services through Optum. If you have medicaid, please bring your medicaid card and any additional insurance information to your first appointment.

Professional Fees

In the event that our fees change during the course of therapy, you will be given written notice of the fee increase. Our current fees for therapy and other professional services are:

Initial Diagnostic Assessment (Intake)	- $200
Individual Play Therapy Session (45 min)	- $140
Parent Consultation	- $130
Summary Letter	- $50
Preparation of Records	- $200/hr

Legal Involvement/Court Fees

Counselors at Play Therapy House, Inc. DO NOT participate in custody hearings, custody disputes, visitation, mediation, or divorce proceedings. Counselors will report any suspicions of abuse and neglect, however we DO NOT investigate these instances. It is not your counselor's role to determine whether abuse or neglect has occurred. These roles are not within our scope of practice. If you require assistance in these areas, please contact a parent coordinator, mediator, department of health and welfare, or another neutral party to assist you.

Play Therapy House, Inc. will not release any confidential information about you or child unless given your written permission or in the case that we are subpoenaed by a judge. If litigation evolves for any reason, information will ONLY be released with a valid court order issued by a judge. If legal involvement evolves, your counselor will provide you with our fee disclosure form which includes a base retainer fee and an hourly rate for any time spent working on your case in or out of court. These fees are non-negotiable and not billable to insurance.

Consent

I have read and understand the client rights and responsibilities statement. I acknowledge that the client rights and responsibilities have been explained to me and my questions have been answered to my satisfaction. I agree to comply with the above information, and to give my informed consent to my clinician to evaluate and consult on care and treatment. I acknowledge that I was provided with the notice of privacy practices and that I have read (or have had the opportunity to read) if I so chose. I further acknowledge that I have been informed and understand that this informed consent may be revoked at any time by clearly communicating such revocation to a Play Therapy House, Inc. clinician.

_____

Client Name (please print) Date

_____

Parent/Guardian (as necessary) Date

_____

Client/Parent/Guardian Signature Date

_____

Clinician Signature Date

Filing a Complaint

If you are dissatisfied with the services you have received for any reason, you have the right to file a complaint. We will not take any action against you or change our treatment of you in any way if you file a complaint. To file a written complaint with us, you may bring it directly to our attention, or mail it to:

Play Therapy House, Inc.
2577 S. Five Mile Rd.
Boise, ID 83709
208-639-1897

If you wish to file a complaint with the Idaho Licensing Board of Professional Counselors you can do so online at:

https://ibol.idaho.gov/IBOL/AgencyAdditional.aspx?Agency=427&AgencyLinkID=65

You may also do so by filling out their complaint form and mailing it to:

IBOL-Investigative Unit
700 W. State Street
PO Box 83720
Boise, ID 83702

Phone: 208-334-3233
Fax: 208-334-3945

Our Therapists:

Jaclyn Moore
LCPC 6879, Registered Play Therapist
MS in Counseling from Northwest Nazarene University

Kailee McMahon
LCPC 6860, Registered Play Therapist
MS in Counseling from Northwest Nazarene University

HIPAA: Notice of Privacy Practices and Client Rights
Your Rights, Our Responsibilities

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

Effective Date: 8/15/18

Play Therapy House, Inc. is required:

- By law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this *notice* upon request.
- To only release information in accordance with state and federal laws and the ethics of the counseling profession.
- To abide by the terms of the *Notice of Privacy Practices* that is most current. We reserve the right to change the terms of the *Notice* at any time. Any changes will be effective for all protected health information that we maintain. The revised *Notice* will be posted in the waiting room and on our website, www.playtherapyhouse.com. You may request a copy of the revised *Notice* at any time.

There is a designated Privacy Officer to answer your questions about privacy practices and to ensure compliance with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information on how to file a complaint. **Our privacy officer is Kailee McMahon and she can be reached at 208-639-1897.**

This notice describes Play Therapy House, Inc. policies related to the use and disclosure of a client's healthcare information.

Use and disclosure of protected health information:

- We will only disclose your protected health information in order to carry out treatment, collect payment, and conduct health care operations. State and federal laws allow us to use and disclose your health information for these purposes.

We may use or disclose information:

- In your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we need an opinion about your condition from a specialist, we may disclose information to that specialist to obtain that consultation.
- In your record to consult with other licensed staff members at Play Therapy House, Inc. about your diagnosis or treatment.
- From your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.
- From your record in order to process payments or collect fees, whether from an insurance company or collections agency.
- From your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers.

The following is an introduction to your rights and responsibilities as a client of counseling services. This notice, in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), describes how your medical information may be used and disclosed and how you can get access to this information.

The counselors at Play Therapy House, Inc. are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. **Effective 8/15/18:**

How We Protect Your Health Information

- All of your health information that we collect is confidential.
- Access to your health information is restricted to clinical staff that needs to know your health information in order to provide services to you.
- Physical, electronic, and procedural safeguards which comply with federal and state regulations guarding your health information.
- Records of client health information are maintained in a confidential, locked file system. The client files remain the property of your counselor, but the information belongs to you.

Voluntary Release of Health Information

- Your counselor may disclose information to outside treatment or healthcare providers with your written authorization. You may revoke such authorizations at any time provided each revocation is in writing.
- Your counselor may use your information to develop accounts receivable information and with your consent, provide information to your insurance company for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.

Mandatory Disclosures with Neither Consent Nor Authorization

Your counselor may disclose your mental health information without your consent or authorization in the following circumstances:

- **Abuse** -- If your counselor has reason to believe that a minor child, elderly person, or person with a disability has been abused, abandoned, or neglected, your counselor must report this concern to the appropriate authorities.
- **Judicial and Administrative Proceedings as Required --** If you are involved in a court proceeding and a court subpoenas information about the professional services provided you and/or the records thereof, your counselor may be compelled to provide the information. Your counselor will not release your information without attempting to notify you or your legally appointed representative.
- **Injury to Self or Others --** If you communicate to your counselor an explicit threat of imminent physical harm to yourself or others, we have a legal duty to take the appropriate measures, including disclosing information to the police.
- **USA Patriot Act of 2001 --** Under certain circumstances, your counselor may disclose information for specialized government purposes, such as military, national security and intelligence, or protection of the President.

Client's Rights:

Rights to Request Restrictions -- You have the right to request additional restrictions on certain uses and disclosures of protected health information. Your counselor may not be able to accept your request, but if they do, they will uphold the restriction unless it is an emergency.

Right to Alternative Means and at Alternative Locations -- You have the right to request and receive confidential communications of mental health information by alternative means and at alternative locations. (For example, you may not want a family member to know you are being seen by a counselor. On your request, your counselor will send your information to another address).

Right to Inspect and Copy -- You have the right to inspect or obtain a copy of your clinical records. A reasonable fee may be charged for copying. Access to your records may be limited or denied under certain circumstances, but in most cases, you have a right to request a review of that decision. On your request, we will discuss with you the details of the request and denial process.

Right to Amend -- You have the right to request in writing an amendment of your health information for as long as the mental health information records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.

Right to an Accounting -- You generally have the right to receive an accounting of disclosures of mental health information. If your mental health information is disclosed for any reason other than treatment or health operations, you have the right to an accounting for each disclosure of the previous six (6) years, but the request cannot include dates before August 1, 2005. The accounting will include the date, name of person, or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.

Electronic Information -- Requests for client mental health information for the purpose of consultation are honored through phone and postal mail communication only.

Grievance -- To file a grievance, you may contact the Idaho Licensing Bureau: 208-334-3233 or contact our Privacy Officer Kailee McMahon at 208-639-1897.

I have read and understand the HIPAA Privacy Practices. I acknowledge that the privacy practices have been explained to me and my questions have been answered to my satisfaction. I agree to comply with the above information, and to give my informed consent to my clinician to evaluate and consult on care and treatment. I acknowledge that I was provided with the notice of privacy practices and that I have read (or have had the opportunity to read) if I so chose. I further acknowledge that I have been informed and understand that this consent may be revoked at any time by clearly communicating such revocation to a Play Therapy House, Inc. clinician.

_____

Client/Guardian Signature Date

COMPREHENSIVE DIAGNOSTIC ASSESSMENT

Family Information

Child's Name: _____ Date: _____

Gender with which child identifies: _____ Referred by: _____

Person Completing Form: _____ Relationship to Child: _____

Residence of Child:

- ☐ Biological/Step Parents
- ☐ Adoptive Parents
- ☐ Foster Parents
- ☐ Residential Treatment
- ☐ Other: _____

Individuals living in the household (Name, Age, DOB):

_____
_____
_____
_____

Reasons for Therapy

Please describe why you are seeking therapy for your child:

Has this problem affected your child's functioning (Please explain frequency/severity):

- ❑ At home: _____
- ❑ At school: _____
- ❑ In the community: _____

What do you hope to see your child accomplish through therapy?

Please describe any previous counseling the child has received:

When: _____

Previous Counselor's Name: _____

Reason for Therapy: _____

Diagnosis: _____

Outcome: _____

Child's Behavior Assessment

Describe the child's temperament. Check all that apply:

- ❑ Easily distracted
- ❑ Easy-going
- ❑ Focused
- ❑ Hesitant
- ❑ High-intensity
- ❑ Quiet/timid
- ❑ Sensitive
- ❑ Slow to transition
- ❑ Startles easily
- ❑ Transitions easily
- ❑ Unpredictable
- ❑ Other: _____

Does the child have a history of any sensory concerns? Over sensitive to:

- ❑ Sounds/Loud noises
- ❑ Smells
- ❑ Touch
- ❑ Light
- ❑ Other: _____

Please indicate if your child is experiencing problems with any of the following:

- ❑ Anger
- ❑ Anxiety/worry
- ❑ Attention Span
- ❑ Changes in eating habits
- ❑ Cruelty to animals
- ❑ Destroying property
- ❑ Disobedience
- ❑ Distorted body image
- ❑ Fatigue
- ❑ Fears
- ❑ Headaches/stomach aches
- ❑ Hearing/seeing strange things
- ❑ Hyperactivity
- ❑ Hopelessness/helplessness
- ❑ Intrusive thoughts/memories
- ❑ Irritability
- ❑ Lack of interest in things
- ❑ Language impairments
- ❑ Low self-esteem
- ❑ Lying
- ❑ Mood shifts
- ❑ Nightmares
- ❑ Obsessive thoughts/compulsive behaviors
- ❑ Panic attacks
- ❑ Paranoia
- ❑ Poor grades
- ❑ Procrastinates
- ❑ Relationships
- ❑ Runs away
- ❑ Sadness/crying
- ❑ School truancy/expulsion
- ❑ Sexual behavior
- ❑ Sleep disturbances
- ❑ Stealing
- ❑ Suicidal talk/self-harm behaviors
- ❑ Tantrums
- ❑ Toileting (wetting/soiling)
- ❑ Violence
- ❑ Withdrawal/Isolation
- ❑ Worthlessness
- ❑ Other: _____

When did these behaviors begin?

Were there any changes occurring in this child's life around that time? Please explain

Has this child expressed any suicidal thoughts or actions?

- ❏ No
- ❏ Yes (please explain):

_____

_____

Developmental History

Did the child's mother experience any of the following problems during pregnancy?

- ❏ Accidents or injuries
- ❏ Alcohol use
- ❏ Bleeding
- ❏ Diabetes
- ❏ Domestic abuse
- ❏ Drug use
- ❏ Emotional stress
- ❏ High blood pressure
- ❏ Illness or infection
- ❏ Tobacco use
- ❏ Toxemia
- ❏ Other: _____

Describe any problems or complications with the delivery of this child:

Did the child's mother experience any postpartum difficulties following delivery?

Describe any accomplishments, which the child mastered and then lost:

- ❏ Feeding
- ❏ Speech
- ❏ Toileting
- ❏ Walking/Crawling
- ❏ Other: _____

Please rate your perception of your child's development compared to peers of the same age:

Social development:

|----------|----------|----------|----------|
Below average Average Above average

Physical development:

|----------|----------|----------|----------|
Below average Average Above average

Language development and skills:

|----------|----------|----------|----------|
Below average Average Above average

Intellectual development:

|----------|----------|----------|----------|
Below average Average Above average

Emotional development:

|----------|----------|----------|----------|
Below average Average Above average

Physical Health History

Current medications (over the counter/prescription)	Purpose	Dosage/Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the child ever experienced any of the following health problems in the past:

- ❑ Allergies: _____
- ❑ Chronic illness
- ❑ Ear/hearing problems
- ❑ Head injury
- ❑ Seizures
- ❑ Tics
- ❑ Vision
- ❑ Weight loss/gain

Describe any current health problems:

Describe any prior hospitalizations:

Play Therapy House, inc.

Academic History

Please list all schools your child has attended (K-12):

Grade:	School:	City:	Attitude about school/grades:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does your child participate in any special education services at school? (IEP, 504b plan)

Was it easy or difficult for the child to be apart from you during the first year of school? Please explain

Please describe the nature of the child's friendships and peer relationships (i.e. are they generally younger, same age, older, short term, long term, friendly, or conflictual?)

Family Information

Describe the child's relationships with family members:

Are there marital or parenting struggles? Please explain:

Describe how the child is disciplined and for what reasons:

Has the child experienced any significant family changes?

- ❏ Death in family (who/when?): _____
- ❏ Divorce or separation of parents (when?): _____
- ❏ Foster care/out of home placement (when/length?): _____
- ❏ Frequent moves(how many?): _____
- ❏ Incarceration of parent(when/who?): _____
- ❏ Experienced or witnessed abuse (physical/emotional/sexual/neglect/domestic violence):

  _____
- ❏ Long term illness/injury/addiction of family member (who/when?):

  _____

Family Mental Health History

Have any family members been diagnosed with any of the following mental health conditions?:

- ❏ ADD/ADHD (who?): _____
- ❏ Anxiety/panic attacks (who?): _____
- ❏ Alcohol/drug abuse (who?): _____
- ❏ Bipolar disorder (who?): _____
- ❏ Depression (who?): _____
- ❏ Learning disability (who?): _____
- ❏ Suicide attempts (who?): _____
- ❏ Schizophrenia (who?):_____
- ❏ PTSD (who?):_____
- ❏ Other Diagnosis (what/who?):_____

What are your child's strengths and interests?

Do you have any other concerns that have not been addressed?

How will you know when your child is ready to graduate from therapy?

Client signature: _____ Date:_____

Parent signature: _____ Date:_____

Clinician signature: _____ Date:_____

Play Therapy House, inc.

Client Name: _____

Release of Information

Play Therapy House, inc. is hereby authorized to release to, receive from, and/or exchange written and verbal information with the following person and/or agency regarding my involvement with the counseling center.

_____

Name of Person or Agency releasing information to (ex: school, doctor, other parental figure)

_____

Street City State Zip Phone

The following information:

❑ Record of service dates and type of service ❑ Service Notes ❑ Assessment Results

❑ Other:

This consent will expire in 365 days and may be revoked by me at any time. I acknowledge that the information to be released may include material that is protected by law. Those receiving this information are prohibited from re-disclosing these records unless expressly permitted by my written consent. My signature below authorizes release of all such information.

_____

Client or Guardian Name

_____ _____

Client or Guardian Signature Date

_____

Client Name

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

Client Information & FAQs About ICANS

What is ICANS?

ICANS is an electronic, internet-based system used to administer and manage the Children and Adolescent Needs and Strengths (CANS) Assessments in Idaho.

Why do I want my child's information available in ICANS?

The Child and Adolescent Needs and Strengths (CANS) is a tool for measuring your child and family's needs and strengths. The CANS is used in Idaho to help determine a child or youth's level of functional impairment and guide treatment planning decisions. In Idaho, the ICANS system uses the information from the CANS Assessment to help clinicians and other providers of children mental health services recommend the appropriate level of care.

To participate in or receive certain state-funded programs, such as the Youth Empowerment Services (YES Program), a child/youth will need to complete a CANS Assessment.

ICANS is the Idaho approved platform to administer and score the CANS. By not allowing your child's information to be available in the ICANS system your child may not be able to access certain state-funded services or programs.

Permitting your child's information to be entered into the ICANS system allows it to be available to authorized providers and staff to make more informed, collaborative decisions regarding your child's mental health services and care.

Why do I need to complete and sign the informed consent?

By completing and signing the informed consent release form, you allow the agency listed to enter your child's information into the ICANS system.

Without the completed and signed informed consent release form, your provider cannot enter your child's information into the ICANS system.

Who may input my child's information into the ICANS system?

The agency that you have named at the top of the informed consent release form has permission to add your child's information to ICANS.

Who will have access to your child's information in ICANS?

Authorized users may have access to your child's information in ICANS.

An authorized user is an individual designated by a provider agency or Idaho Department of Health and Welfare Division of Behavioral Health needing to access ICANS for their job.

Examples of potential authorized users may include, but are not limited to:

- Division of Behavioral Health Children's Mental Health staff.
- Division of Family and Community Services (FACS) staff, including Developmental Disabilities and Child Welfare if your child is involved in their programs.
- Medicaid and/or Optum staff who are responsible for the coordination, payment, and quality management of behavioral health services in Idaho.
- Independent Assessment providers, who are contracted by Medicaid, who will assess children for eligibility for some state-funded children's mental health services.

All ICANS users must also abide by the ICANS policies and procedures which include Health Insurance Portability and Accountability Act of 1996 ("HIPAA") privacy and security standards. Use of the ICANS system for any other reason is strictly prohibited.

What information may be viewable by ICANS authorized users?

Limited information entered into the ICANS system is viewable to all authorized users.

Only the following information in the ICANS system **may be shared** with all authorized users:

- Last Name
- First Name
- Birth Date
- Social Security Number*
- Gender
- Race
- Ethnicity
- Address
- Identifiers (other numbers such as Medicaid ID number)

*The Social Security Number (SSN) is collected for the purpose of identification of the participants, prevention of duplication of benefits and information. The SSN is a fundamental component for case management and care coordination activities.

The Department of Health and Welfare is authorized to collect and use social security numbers (SSN) to determine Medicaid eligibility, verify information, and prevent duplicative participation. Providing your SSN may minimize administrative delays associated with the requested service. The Department will not disclose an individual's SSN without the consent of the individual to anyone outside of the Department except as mandated by law. 31 CFR 1.32; 42 CFR §435.910.

The following information in the ICANS system is **not shared** with authorized users without a specific signed Release of Information:

- Diagnosis(s)
- Any information related to Substance Use.
- Ratings on any of the CANS items.
- Comments entered into ICANS related to the CANS scoring.
- Recommended Level-of-Care outcomes

How do I share my child's information between my child's treatment providers?

A specific completed and signed Release of Information must be completed *in addition* to the ICANS informed consent release form so that your child's provider can access records completed by another provider agency.

What information may be viewable by my child's treatment provider?

Your child's treatment provider can access any ICANS records for your child that have been entered by that specific provider and/or agency.

Please Note: A specific signed Release of Information must be completed *in addition* to the ICANS informed consent release form so that your child's provider can access records completed by another provider agency. The following information is available to your child's provider:

- Last Name
- First Name
- Birth Date
- Social Security Number*
- Gender
- Race
- Ethnicity
- Address
- Identifiers (other numbers such as Medicaid ID number)
- Diagnosis(s)
- Any information related to Substance Use.
- Ratings on any of the CANS items.
- Comments entered into ICANS related to the CANS scoring.
- Recommended Level-of-Care outcomes

Can I revoke the ICANS informed consent release form?

You may revoke the ICANS informed consent release form at any time. This will prevent any future use of ICANS but does not change any action that has already taken place using the informed consent release form.

After the informed consent release form has been revoked, the informed consent release form is no longer valid from that date forward. Copies or exact reproduction of the completed and signed informed consent release form will have the same force and effect as the original.

How is my child's privacy protected?

Information shared through ICANS is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2; 45 C.F.R. Parts 160 & 164; and the Medicaid Act, 42 C.F.R. Part 431, Subpart F.

The ICANS system and participating providers use a combination of safeguards to protect your child's health information.

- Technical safeguards include encryption, password protections, and audit logs that track every participant's use of the system.
- Administrative safeguards include written policies that require limited access to information through ICANS. All participating providers must agree to follow these policies.
- The ICANS Security Safeguards can be found online at: http://icans.dhw.idaho.gov/ResourcesandUserGuide/tabid/4105/Default.aspx

All participating providers are also regulated by HIPAA, and other federal and state privacy laws. Providers must also have their own policies and other safeguards in place, including policies to train their staff and limit access to those who have a need to know.

Have questions not covered by this flyer or have concerns?

Please speak with your local Idaho Department of Health and Welfare Children's Mental Health office.

healthandwelfare.idaho.gov

IDAHO DEPARTMENT OF
HEALTH & WELFARE

ICANS Informed Consent

I, _____ *(parent's name)*, am the parent or legal guardian of

_____ *(minor client's name)* whose date of birth is:_____.

I have received a brochure explaining how ICANS is a secure electronic health system used to administer the ICANS assessment, and make the results available to providers who participate in the ICANS system.

I authorize the following Agency _____ (*name of provider/agency/ organization)* to release, use, receive, mutually exchange, communicate with and disclose information to the ICANS system, and with Agencies/Authorized Users with access to ICANS.

WHO MAY DISCLOSE INFORMATION. The agency I have named at the top of this form may disclose protected health information to ICANS.

WHAT MAY BE DISCLOSED. By signing this consent, I specifically understand that protected health information or records will be released, used, disclosed, received, mutually exchanged or communicated to, by, among, or between any person, entity, or agency named in this authorization. I understand this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164; and the Medicaid Act, 42 CFR Part 431, Subpart F. Federal rules restrict any use of the information to criminally investigate or prosecute and to redisclose records relating to any alcohol or drug abuse patient.

PURPOSES.
I understand this authorization will allow my treatment team to plan and coordinate services I need and allows any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization.

REVOCATION.
I also understand that I may revoke this Informed Consent at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically as indicated with each disclosure item identified above. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

EXPIRATION
This authorization shall expire one (1) year from the date the Minor Client and Parent or Legal Guardian signs below.

CONSENT.
I understand that my information cannot be disclosed without my written consent, except as otherwise provided by law, and that federal and Idaho law will be followed for using and disclosing my ICANS information.

By signing this form, I am authorizing providers assessing or treating my child/ward to provide my child/ward's information to ICANS. I understand that failure to sign this authorization may limit determine of eligibility, enrollment, or treatment for my child/ward.

I have read this Informed Consent/had this Informed Consent read/explained to me and I acknowledge an understanding of the purpose for the release of information. I am signing this authorization of my own free will.

Full Legal Signature of Minor or Authorized Personal Representative	**Relationship to Client**	**Date**
Full Legal Signature of Parent or Legal Guardian – ***Required if Client is under 16 years of age, but only after signed by client.***	**Relationship to Client**	**Date**
Full Legal Signature of Witness (Agency Employee)	**Initiating Agency Name**	**Date**

ALERT® Wellness Assessment - Youth

Completing this brief questionnaire will help us provide services that meet your child's needs. Answer each question as best you can and then review your responses with your child's clinician. Shade circles like this ●

Child's Last Name , First Name — Child's Date of Birth: (mm/dd/yy) / /

Subscriber ID — Authorization #

Clinician Last Name , First Name — Today's Date: (mm/dd/yy) / /

Clinician ID/Tax ID: 8 3 0 5 9 9 1 3 6 — Clinician Phone: 2 0 8 6 3 9 - 1 8 9 7 — State: I D — *MRef* ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

Relationship to child: ○ Mother ○ Father ○ Stepparent ○ Other Relative ○ Child/Self ○ Other

For questions 1-21, please think about your experience in the past week.

Fill in the circle that best describes your child:	*Never*	*Sometimes*	*Often*
1. Destroyed property	○	○	○
2. Was unhappy or sad	○	○	○
3. Behavior caused school problems	○	○	○
4. Had temper outbursts	○	○	○
5. Worrying prevented him/her from doing things	○	○	○
6. Felt worthless or inferior	○	○	○
7. Had trouble sleeping	○	○	○
8. Changed moods quickly	○	○	○
9. Used alcohol	○	○	○
10. Was restless, trouble staying seated	○	○	○
11. Engaged in repetitious behavior	○	○	○
12. Used drugs	○	○	○
13. Worried about most everything	○	○	○
14. Needed constant attention	○	○	○

How much have your child's problems caused:	*Not at All*	*A Little*	*Somewhat*	*A Lot*
15. Interruption of personal time?	○	○	○	○
16. Disruption of family routines?	○	○	○	○
17. Any family member to suffer mental or physical problems?	○	○	○	○
18. Less attention paid to any family member?	○	○	○	○
19. Disruption or upset of relationships within the family?	○	○	○	○
20. Disruption or upset of your family's social activities?	○	○	○	○

21. How many days in the past week was your child's usual routine interrupted by their problems? ☐ Days

Answer the following only if this is your first time completing this questionnaire for this child.

22. In general, would you say your child's health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
23. In the past 6 months, how many times did your child visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
24. In past month, how many days were you unable to work because of your child's problems? *(answer only if employed)* ☐☐ Days
25. In the past month, how many days were you able to work but had to cut back on how much you got done because of your child's problems? *(answer only if employed)* ☐☐ Days

59243

Clinician: Please fax to (800) 985-6894

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