Consultants for Children, Inc.

Club Spark Application Packet
(Non-CFCI Client)

Dear Family and Camper,

We would like to welcome you to Consultants for Children, Inc. Club Spark! We are looking forward to a fantastic, fun, social learning experience! The enclosed forms must be completed and returned prior to your child attending club. This packet is required of all participants at this time. If you require additional copies, visit our website at *www.sparkclubs.com*. In addition to the forms, a registration fee of $65/child must be submitted with your application. Please write checks payable to Consultants for Children, Inc.

Consultants for Children, Inc. accepts many types of insurances and funding sources, in the case that we aren't a provider for your insurance, or you don't have coverage, private pay will then be discussed. Club will be from 9am-2pm. An attachment is provided listing available dates. Please mark the dates you are planning on attending. We will have a one-week session. Also, please note that there will be an activity fee of $3.50 for everyday your child attends.

Please use the following checklist to verify that all information has been submitted, as all information provided will be used to determine your child's readiness and the goals that we will focus on throughout club.

****NEW FOR 2018: Summer Club is only available for 4-10-year-old, with exceptions, and must be currently receiving ABA services!**

_____ $65 onetime non-refundable Registration Fee
_____ Day Camp Application
_____ Emergency Form
_____ Days attending (see attachment)
_____ Copy of Insurance Card (Front and Back)
_____ Recent Photo of the Child
_____ Treatment Plan from current ABA provider
_____ Sick Child Policy
_____ Release of Liability
_____ Photo/Media Release
_____ Release of Information
_____ Agency Disclosure
_____ Copy of Diagnosis

Please complete this intake and return it to the office. After you have returned all information a treatment plan will be made. Please note that your child cannot start Club until the treatment plan is made.

Please note that participation is not guaranteed, however we will do our best to accommodate you. It is our priority to provide a safe and therapeutic environment for every child and staff member, as well as the community. If at any point your child presents with severe aggression or elopement issues, and we determine that your child is not fit to be with us, you will be asked to pick up your child early. In this case there is likelihood that services may be suspended or canceled, while a treatment plan is updated and the staff working with your child are trained. We may suggest that your child receive in-office services or in-home services to provide your child with the care he/she may need. In the case that your child needs more than one on one supervision or a male technician, accommodation is not guaranteed. All of these happenings will be at the discretion of the directors.

If you have questions, please feel free to contact us by phone or email. We would be happy to answer any question you may have regarding Day Camps.

Thank you,

Stephanie Kimmen
Head of Administration

Family Information

Child's Name:

First Middle Last

Nickname: Date of Birth: Gender:

Address:

Number & Street, Apt. # City, State Zip

Does your child have a diagnosis? Yes No

If yes, what is the current diagnosis?

Date diagnosed: Age at diagnosis: Diagnosed by:

Was this diagnosis firm or questionable?

Educational Background

Does your child attend school? Yes No

What is the name of the school?

What type of program does your child attend?

Is there a current IEP? (If so, please provide a copy) Yes No

Families Primary Language: Secondary Language:

Payment Information

The Camper's fees will be paid by:

Parents/Guardians Agency CCB Self Insurance Other:

Insurance Company Provider #:

Policy Number:

CCB Resource Coordinator Contact info:

(please provide a copy of the insurance card)

Parent/Legal Guardian #1

Name: Date of Birth:

Address

Number & Street, Apt. # City, State Zip

Occupation:

Home: Cell#: Work#:

E-Mail Address:

Parent/Legal Guardian #2

Name: Date of Birth:

Address

Number & Street, Apt. # City, State Zip

Occupation:

Home: Cell#: Work#:

E-Mail Address:

Parents are: Married Separated Divorced

Who has custody of the client?

Is the child adopted? Yes No

General Behavior
When does your child best listen to parent instruction?

Self Injurious Behavior: Y N
Describe context in which it usually occurs (at home, in the natural environment, with peers, with adults):

Frequency: Consequences Used:

Non-Compliance: Y N
Describe the context in which it usually occurs (at home, in the natural environment, with peers, with adults):

Consequences Used:

Tantrums: Y N
Describe the context in which it usually occur (at home, in the natural environment, with peers, with adults):

Describe nature of tantrum (*i.e., throws self on floor, etc.):*

Duration of typical tantrum:
Frequency: Consequences Used:

Aggression:
Towards Self Y N
Towards Others Y N (are other children a trigger)
Towards Property Y N
Describe context in which it usually occurs (at home, in the natural environment, with peers, with adults):

Describe nature of aggressive behaviors:

Frequency: Consequences Used:

Running Away: Y N
Describe context in which it usually occurs (at home, in the natural environment, with peers, with adults):

Frequency: Consequences Used:

Spitting: Y N
Describe context in which it usually occurs (at home, in the natural environment, with peers, with adults):

Frequency: Consequences Used:

Other Behaviors:
Behavior:
Frequency: Consequences Used:

Self Stimulatory Behaviors
Repetitive Mannerisms: (hand flapping, flicking, gazing, lining up objects, hoarding objects, toe walking, running back and forth, etc.):

Unusual attachments to objects:

Repeats previously heard words out of context (echolalia):

Verbalizing in a repetitive manner (i.e. eee sounds, babbling, screaming, etc.):

Difficulty with transitions or changes in routine:

Unusual interest in the sight, feel, sound, or smell of things:

Unusual preoccupations/obsessions (anything he/she likes to do repeatedly):

Social Behavior
Does your child show you affection? How?

How does your child play with other children?

How does your child play with toys?

Please list your child's favorite toys, activities, music, food, games, etc:

Does your child give eye contact? Y N
Does your child respond to his/her name? Y N
Does your child come to you for comfort? Y N

Does your child greet you in anyway when he/she sees you? Y N How?

Does your child show interest in other people? Y N
Please indicate whom and how your child shows interest in other people:

Does your child attempt to involve you in something he/she is doing? Y N
Please describe some examples:

Does your child get involved with something you are doing? Y N
Please describe some examples:

General Language
Did your child have speech that he/she lost? Y N
If yes, at what age did he/she start to lose speech?
Was he/she ill at the time of loss? Y N

What is your child's usual way of communicating (verbally, sign language, pecs, device etc.)?

If communication device, will child have access to device during club? Y N

Does your child cry to let you know if he/she wants something? Y N
Does your child take you or point to what he/she wants? Y N
Does your child say what he/she wants? Y N

Receptive Language
Does your child follow verbal instructions without visual cues? Y N
How much do you think your child understands?

Expressive Language
Does your child have any words? If yes, please give examples:

Are the words your child has used in context or out of context?

Does your child babble or combine sound so that the combined sounds resemble some speech?

Are there any words that your child imitates? If yes, please list the words:

What is the average length of your child's utterances?

Are there problems with your child's articulation or intonation of speech?

Can your child hold a conversation about a favorite topic? Y N
If yes, please describe:

Please list any additional comments you would like to make regarding your child's speech and language:

Self Help Skills
Please list your child's current level of functioning on the following skills:

Toileting: (Please note we will not be working on toileting as a goal during club. However, we will assist/prompt your child if needed.) Is there a toileting schedule that you would like us to follow?

Feeding:
How does your child eat now?

Describe your child's typical diet:

Dressing:
What level of support does your child need regarding self-care (toileting, eating, washing hands, etc.)?

Are there any responsibilities outside of therapy services Consultants for Children, Inc. staff will need to have during sessions with your child (for example, changing diapers, etc.)? *please note that staff is not allowed to administer medication

Describe your child's current physical health:

Does your child have seizures? Y N
If no, has your child had seizures in the past? Y N
If yes, please indicate frequency of seizures:
Length: Type:
Do they take medications for this? Y N

Current Services
Please list your child's previous and current services:
Service 1:
Type of Treatment:
Service Provider:
Duration of Treatment:

Service 2:
Type of Treatment:
Service Provider:
Duration of Treatment:

Service 3:
Type of Treatment:
Service Provider:
Duration of Treatment:

Service 4:
Type of Treatment:
Service Provider:
Duration of Treatment:

Goals and Objectives:
Please list some goals that you would like your son/daughter to achieve:

[Type here]

What are your child's favorite activities:

Does your child have any particular dislikes or things/situations that make him/her feel uncomfortable?

Where did you learn about Consultants for Children, Inc.?
Is there other additional information you would like us to know about your child/family including family info, allergies, fears, etc?

Club Spark runs from 9am to 2pm as follows,
Please indicate days/session(s) you are registering:

We will have one-week session. Please mark the dates you are planning to have your child attend.
Also, please note that there will be an activity fee of $3.50 for everyday your child attends.

Lakewood Summer Club June 4th-29th and July 9th-August 3rd, 2018

M	Tu	W	Th	F		M	Tu	W	Th	F
4	5	6	7	8		9	10	11	12	13
11	12	13	14	15		16	17	18	19	20
18	19	20	21	22		23	24	25	26	27
25	26	27	28	29		30	31	1	2	3

WHAT TO BRING

The following is a list of items your child needs to bring with him/her to extended clubs. Please have all items kept together in a bag or backpack that is clearly marked. Also please mark all personal items (cups, clothes, shoes, etc) with your child's name in permanent ink. Dress for the weather – it is better to be over-prepared than under.

Must Have's:

- Money for the cost of admission for the days activity
- Sunscreen (please send your child with sunscreen applied and extra to reapply)
- Bagged lunch; water; drinks
- Extra diapers, wipes, and rash lotion (if applicable)
- Swimming apparel and towel (when applicable)

Other Possible Item's:

- Extra change of clothing
- Any medications needed that are clearly labeled with written instructions. Please hand to a staff member; this should not be placed in child's bag.
- Favorite toys, games, etc., that staff can use for reinforcement
- Any items they would like to share with the group

BASED OFF THE SEASON, PLEASE DRESS YOUR CHILD APPROPRIATELY FOR OUTSIDE PLAY, INLUDING SAFE AND COMFORTABLE SHOES

Consultants for Children, Inc.

PROGRAM INFORMATION / EMERGENCY FORM

Emergency Contacts/Pick Up List: Please list all possible contacts. For non-family members, please indicate whether or not that person had permission to pick up your child from club. If there are any changes a new form will need to be done.

Name	Relationship	May Pick Up?	Primary Phone	Secondary Phone
	Parent	Yes No		
		Yes No		
		Yes No		
		Yes No		

Please list any allergies and/or sensitivities or intolerances (including foods ie. special diets): _____
_____

Please list any medications your child will be taking while with CFCI:

Medication	Dose	Time of Day	Special Considerations

By signing below you agree to only include a daily dose of medication labeled with specific instructions and the child's name. ***<u>The child MUST be able to self-administer the medication</u>***

In case of an emergency we will call 911. We will request to have your child taken to a medical facility of your choice.

Hospital(s) of choice:
Medical Insurance Info:
Primary Care Physician and number:

Pick-Up Policy/ Late Pick-Up Policy/Sick or Behavioral Pick-Up Policy
I understand the participant will only be released to a Parent, Legal Guardian, or Emergency Contact. An Emergency Contact must have valid picture identification for the child to be released. Participants are to be picked up no later than 2:00pm (unless otherwise arranged). The child may not return to the program if two or more late pick-ups occur. Sick participants or participants experiencing behavioral issues must be picked up within one hour of the notification call.

I have read and understand the Pick-Up Policy and will abide by such policy to ensure the safety of all participants.

Parent/Guardian's Printed Name: **Relation**

Parent/Guardian's Signature: **Date:**

www.SparkClubs.com
www.ConsultantsforChildren.com
265 South Harlan Street Lakewood, CO 80226
(720) 272-1289 Office | (888) 300-3081 Fax
(720) 785-4544 Direct | clubspark@cfcico.com

Consultants for Children, Inc.

RELEASE OF INFORMATION

I, parent/guardian of
(Print name of parent/guardian of client) (Print name of client)
hereby give permission to Consultants for Children, Inc. and the clinician(s) performing services in connection with my/my child's treatment to:

Disclose information to and from:

My child's Community Centered Board and current or future case coordinators:
(for example: Developmental Pathways, Denver Options, North Metro Comm. Services, DDRC, Foothills Gateway, Imagine!, Envision, etc)

CCB:

Current Case Coordinator:

Case Coordinator Phone Number:

Case Coordinator E-mail Address:

Address:

My child's Insurance Carrier and current or future case coordinators:

Insurance Carrier:

Current Case Coordinator:

Case Coordinator Phone Number:

Case Coordinator E-mail Address:

Address:

My child's School and current or future employees of the school or district who work with my child:

Current School Name:

Current Teacher:

Current Other Staff:

School Address:

School Phone Number:

Teacher E-mail Address:

Address:

My child's Speech Therapist:

Speech Therapist's Name:

Speech Therapist's Phone Number:

Speech Therapist's E-mail Address:

Address:

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My child's Occupational Therapist:

Occupational Therapist's Name:

Occupational Therapist's Phone Number:

Occupational Therapist's E-mail Address:

Address:

My child's Primary Care Physician:

Primary Care Physician Name:

Primary Care Physician's Phone Number:

Primary Care Physician's E-mail Address:

Address:

My child's Other Providers:

Other Provider's Name:

Other Provider's Phone Number:

Other Provider's E-mail Address:

Other Provider's Address:

Other Provider's Name:

Other Provider's Phone Number:

Other Provider's E-mail Address:

Other Provider's Address:

Additional Family Members:

Family Member Name:

Family Member Phone Number:

Family Member Email Address:

Family Member Address:

Family Member Name:

Family Member Phone Number:

Family Member Email Address:

Family Member Address:

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INFORMATION TO BE DISCLOSED OR OBTAINED (initial all that apply):

My entire mental health record	Treatment recommendations
Expected course of treatment	Attendance records
Diagnosis/Assessment	Treatment plan
Name of new treatment provider	Progress report on treatment
Other, please specify:	

FORM IN WHICH INFORMATION SHOULD BE RELEASED:

Written Verbal Photocopied Email

I may revoke this consent at any time in writing. If I do not revoke this consent, this consent will expire one year from today's date.

Signature of parent/guardian Printed name of parent/guardian

Date Witness

NOTICE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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RELEASE OF LIABILITY
CLUB SPARK & SOCIAL GROUPS

I understand that my child will participate in activities with Consultants for Children, Inc.'s (CFCI) Club Spark that may potentially be physically and/or emotionally demanding. I affirm that I have disclosed all conditions my child has that could potentially endanger his/her health or that of other participants. I agree to assume the risk of physical injury that could result from participating in these activities unless that injury can be proven to be the result of gross negligence on part of the CFCI staff. I release Consultants for Children, Inc. and its staff members, contractors, and outside facilitators from all liability for any injury to my child from participating in Consultants for Children, Inc.'s Club Spark.

I may revoke this consent at any time in writing. If I do not revoke this consent, this consent will expire one year from today's date.

Child's Name Date

Parent/Guardian's Name

Parent/Guardian's Signature Date

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Consultants for Children, Inc.

PHOTO/MEDIA RELEASE

I give the following permission to Consultants for Children, Inc. (CFCI) and its subsidiaries regarding my child, being photographed and/or videotaped during his/her activities with CFCI. These photographs/videos may be used, at your discretion, (1) internally to train staff, (2) externally to train the public and/or (3) increase public awareness and promote the continuation of our programs through the use of mass media displays, brochures, websites, etc. The photographs/videos will never be given to any third parties. All photos will be uploaded to a secure, password protected web-page on www.sparkclubs.com under the "Client Resources" tab, for all families to view their children during the days activities.

Please check all that apply:

For Consultants of Children, Inc.'s website, brochures, and other media

For internal use only (CFCI staff training)

For external use (RBT training)

Only for the purpose of viewing the day's activities via a secure web-page for the families participating in club

I may revoke this consent at any time in writing. If I do not revoke this consent, this consent will expire one year from today's date.

Parent/Guardian's Name **Relation**

Parent/Guardian's Signature **Date**

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Sick Children Policy

Deciding when a child is too sick can be a difficult decision for parents to make. When trying to decide, use the guidelines below and seek the advice of your health care provider.

No need to cancel--- If your child has any of the following symptoms, they should probably go to their session/appointment; sniffles, a mild runny nose with minimal drainage, mild cough without a fever and/or vague complaints of aches, pains, or fatigue

Need to cancel—If your child has any of the following symptoms, please cancel your child's session/appointment and possibly make a doctor's appointment.

There may be many more health issues which would merit exclusion, but these are the most common.

CHICKEN POX (Varicella)	Chicken pox blisters appear in crops and are infectious until ALL blisters are dried and crusted over (usually 5-6 days after star of rash). Keep child home until no longer contagious.
COLDS	A runny nose it not necessarily cause to keep your child home. Keep them home with a runny nose AND a fever, bad cough, headache or nausea, or if the child is too tired or too uncomfortable to function.
DIARRHEA	Keep children home for persistent watery stools especially if the child looks or acts ill. Persistent diarrhea, especially if accompanied by fever and cramps, should be evaluated by your health care provider.
EARS.	Drainage from the ear and/or ear pain should be evaluated by your health care provider. Untreated ear infections can cause temporary and/or permanent hearing loss
EYES	Thick mucus, pus, or clear liquid draining from the eye may be contagious. One or both eyes may also appear extremely red and feel irritated, itchy, or painful. The eyelid may be swollen and the eye may be sensitive to light. Wait until the drainage and symptoms have cleared. You may need to get a prescription for eye drops from your health care provider.
FEVER	A child must be fever free for 24 hours. Cancel your appointment for a temperature of 100 degrees Fahrenheit or higher within the last 24 hours.
FRACTURES OR SURGERY	Please notify your team if your child needs any modifications to physical activity, length of appointment, or mobility needs. You may be asked to provide written information from your health care provider regarding limitations and special needs.
LICE, SCABIES	Please notify Consultants for Children if your child has head lice. For a noted infestation of lice and nits (eggs), your child may not attend an appointment until he/she has been treated.
NASAL DISCHARGE And/or CHRONIC COUGH	These conditions may be contagious and may require treatment. Your child should be seen by your health care provider for evaluation especially if symptoms also include fever and a large amount of mucous drainage.
RASH	Any skin rash of unknown cause may be contagious or require medical treatment, especially with fever and itching. Consult with your health care provider. You may be asked to present a medical excuse from your physician stating that the rash is not contagious (or no longer contagious).
SORE THROAT	A sore throat, especially with fever or swollen neck glands may be contagious. If infected, please notify Consultants for Children to reschedule.
VOMITING	An ill child who is vomiting should remain home for 12-24hrs after the episode and until child has tolerated at least two normal meals. If related to a head injury, a vomiting child should be seen by a physician or in an emergency room. Please report the head injury to Consultants for Children.

I have read and understand the Pick-Up Policy and will abide by such policy to ensure the safety of all participants.

Parent/Guardian's Printed Name: **Relation**

Parent/Guardian's Signature: **Date:**

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CONTRACT FOR SERVICES CLUB SPARK

I hereby authorize the my child, , to participate in Club Spark as defined below, conducted and consulted by the staff of Consultants for Children, Inc. (here-in-out referred to as "Technician(s)") and their Director, Germaine Seufert, M.A., NCC, LPC, CBIS.

1. TERM: I, the parent, understand that the term of this contract is beginning on
2. I, the parent, understand that Consultants for Children, Inc. cannot guarantee my child a spot in Club Spark. Consultants for Children, Inc. must maintain safety of those participating in club, as well as the community. The intake filled out by me, the parent, will be used to determine my child's readiness for club, and I assure its accuracy. If my child is accepted into the program, this does not mean that he/she will not be removed from club if his/her behavior is unsafe. Consultants for Children, Inc. may then suggest in office or in home treatment; it's at my digression whether my child will be participating in alternate services.
3. I, the parent, understand either party may terminate this contract at any time. 24 hours notice must be given to cancel a scheduled day at Club Spark.
4. OBTAINING INFORMATION FROM OTHERS: I, the parent, have agreed to release my child's medical, educational and psychological records to the Technician. The purpose of releasing records is to receive my child's diagnosis, medical history, and evaluation of current intellectual and adaptive functioning. This information will be used to plan the future therapy for my child.
5. SERVICE PROVIDER: I, the parent, understand that Technicians providing services vary in degree of experience, education, and training. I also understand that the Technician holds no responsibility for the treatment staff not employed by Consultants for Children, Inc.
6. TECHNIQUES USED: I, the parent, understand that the goal of Club Spark is to teach and build social skills, and community safety. These techniques may include, but are not limited to: ABA, Behavior Modification, TEACCH, RDI, Floor Time, Play Therapy, and Verbal Behavior.
7. Research has shown that the techniques in the above named therapies are effective with children who are developmentally disabled.
8. I, the parent, understand that the techniques will not necessarily produce observable results during the course of Club Spark attendance, especially for those attending minimal days. The subsequent short and long-term application of the techniques has benefited other children with similar diagnoses as my child, and Consultants for Children, Inc. expects them to benefit my child. However, I understand that my child may or may not benefit, and that my child may experience some distress and may even experience more difficulties during and after participation.
9. TECHNICIANS DUTIES: I, the parent, understand that the Technician will co-create goals and treatments for my child's therapy progress with the parents and other professionals.
10. I, the parent, understand that the Technician will not be working on holidays, if this falls on a weekend, then the Technician will not work the day before or after. I will verify the schedule with the Coordinator.
11. The Technician agrees to work with enthusiasm, patience and appropriate discipline, arrive on time for each of her scheduled therapy sessions and meetings, leave the work area clean and organized when completed work, and help prepare stimulus materials as required by the therapy process.
12. I, the parent, understand that I will need to pack a lunch, water, sunscreen and appropriate clothing each day.
13. I, the parent, understand and agree to the Sick Children Guidelines provided to me in my club manual.
14. FEES: Check the applicable payer
    a. Third Party Payer: I, the parent, understand that Consultants for Children, Inc. is under contract by a third party to provide the above described services and this third party is also paying for these services. Consultants for Children, Inc. may be required by the third party payer to charge me for co-pays, co-insurance or other fees. I agree to pay daily activity admission fees for my child. I will never be asked to pay admission fees for my child's Technician.
    b. Private Payer: I, the parent, understand that Consultants for Children, Inc. is charging $_____ per day for Club Spark and agree to pay the daily fee, plus daily activity admission fees for my child. I will never be asked to pay admission fees for my child's Technician.

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15. I, the parent, understand that my $65 registration fee is non-refundable. The only exception being if my child is funded by Medicaid.
16. I, the parent, understand I am responsible for daily activity admission fees for my child. I must provide this fee at the beginning of each week, or my child will not be able to participate in the activities. If my child misses a day, or adds a day the monies will be exchanged that week. I will never be asked to pay admission fees for my child's Technician.
17. I, the parent, understand that if, at any time, I have questions, and I may write, email or call the Technician at 265 South Harlan Street, Lakewood, CO 80226-2261, (720) 785-4544, clubspark@cfcico.com.

I have read and understand the above information fully. Being informed of the above, I hereby agree to my child receiving treatment from Consultants for Children, Inc. In signing this consent form and contract, I acknowledge that I have received a copy of this form.

My child is a minor (age) and is unable to sign this form.

Signature (Mother or Guardian) Date

Signature (Father or Guardian) Date

In consideration of the promises of the Parent(s)/guardian(s) set forth above, and for other good and valuable consideration, the forgoing contract is hereby accepted and agreed to by the Technician(s).

Germaine Seufert, MA, NCC, LPC Date

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Consultants for Children, Inc.

STATEMENT OF CLIENT FINANCIAL RESPONSIBILITY

Client Name: Client Date of Birth:

Responsible Party Name:

FINANCIAL POLICY

- The client's guardian (or client, if not a minor) is ultimately responsible for the payment for treatment and care.
- Consultants for Children, Inc. (CFCI) will verify the client's eligibility and coverage for services rendered by CFCI staff.
- The client's guardian (or client, if not a minor) understands that CFCI will do our best to obtain insurance coverage and benefit information and that your insurance may deny a service that they previously stated was a covered benefit.
- CFCI will bill the client's insurance for services rendered by CFCI Staff.
- It is the client's guardian's (or client, if not a minor) responsibility to provide the most current and updated information regarding insurance before services are rendered.
- The client's insurance policy is a contract between the client's guardian (or client, if not a minor) and the insurance company, and CFCI is not able to modify coverage, copayments or deductibles.
- The client's guardian (or client, if not a minor) is responsible for payments of copays, coinsurance, deductibles and all other services that are not covered or not payable by their insurance.
- If your insurance denies any part of the claim, the client's guardian (or client, if not a minor) agrees to pay the full balance.
- Non-payment of copays, coinsurance, deductibles, or any other amounts, may result in billing charges, collection activity, and discharge from CFCI.

PAST DUE BALANCES AND COLLECTIONS

- All invoices are due within 15 days.
- Invoices are emailed electronically to the client's guardian (or client, if not a minor)
- Past due accounts greater than 90 days are subject to a $10 per invoice late fee and will accrue interest at the rate of 18%
- If you need special payment arrangements, please contact our Billing Department at 720-839-2873.
- Outstanding balances more than 180 days past due may be turned over to an outside collection agency.

RETRUNED CHECK FEES

- Any returned checks will incur a fee of $20.00

ACKNOWLEDGEMENT

I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.

I may revoke this consent at any time in writing. If I do not revoke this consent, this consent will expire one year from today's date.

Client or Guardian Signature Date

www.SparkClubs.com
www.ConsultantsforChildren.com
265 South Harlan Street Lakewood, CO 80226
(720) 272-1289 Office | (888) 300-3081 Fax
(720) 785-4544 Direct | clubspark@cfcico.com

Consultants for Children, Inc.

DISCLOSURE STATEMENT AND NOTICE OF PRIVACE PRACTICES

This Disclosure Statement provides you (the parent/guardian) with the information regarding the Supervising Therapist for your program. There likely will be additional therapists working with your family. If you want any information about the additional therapists, you are asked to request the information from them directly about their License(s), Degree(s) and Professional Affiliations. The rest of the information contained in this Statement is true for all therapists working for Consultants for Children, Inc.

Supervising Therapist Name: Germaine Seufert, M.A., NCC, LPC
License: Licensed Professional Counselor, State of Colorado, #4416
Degrees: B.A. – Psychology from Metropolitan State College of Denver, 2000
M.A. – Counseling Psychology and Counselor Education from University of Colorado at Denver, 2003

Professional Affiliations: Family and Child Early Interventions – Board Member

American Association for Marriage and Family Therapy – Member

National Board Certified Counselor – National Certified Counselor

Regulatory Agency Information

The Colorado State Department of Regulatory Agencies regulates the practice of both licensed and unlicensed persons in the field of psychotherapy. Any questions, concerns, or complaints regarding the practice of mental health may be directed to: **Mental Health Grievance Board, 1560 Broadway, Suite 1370, Denver, CO 80202 (303-894-7766).** You are entitled to receive information about methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure. Either party may terminate therapy at any time. You may seek a second opinion from another therapist or may terminate therapy at any time. You should know that in a professional relationship, sexual intimacy is never appropriate and should be reported to the grievance board. Reports and other records pertaining to therapy will be kept confidentially on file at 265 South Harlan Street, Lakewood, CO 80226.

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential. Information disclosed is privileged communication and cannot be disclosed. There are exceptions to the general rule of confidentiality, which are listed in the Colorado statutes (C.R.S. 12-43-218). You should understand the information provided by you during therapy is legally confidential except where there is a life-threatening situation and/or an abuse of a child. Also, information may be shared with your insurance company, associated managed care organization, federal or state funding agency, attorneys or collection agency for purposes of reimbursement. A form titled "Release of Information" will be signed by you, the client, prior to my being able to give out any information regarding you, your family, your treatment or any other information.

Authorization to Use and Disclosure of Protected Health Information

By signing below, you are consenting to the use of protected health information, including, but not limited to therapy notes by Germaine Seufert, M.A., NCC and Consultants for Children, Inc. for your treatment and to the disclosure of such information to third parties, including, but not limited to insurance carriers or health plans for payment purposes, other care providers in cases of necessary or requested referrals, or to government agencies in accordance with statutory provisions listed above or if necessary to fulfill any legal obligations to warn of immediate peril to you or others.

Also, you are consenting to limited disclosure of the fact of your status as a patient including, but not limited to, third party notification for payment purposes (banks, credit providers, etc.), incidental contact with mail carriers or the like for delivery of posted mail (appointment reminders, reports being sent to you, invoices, etc.). If you wish to receive such communications at an alternative location or address, please request such accommodations in writing.

Any disclosures of the above-described nature will be limited to that reasonably necessary to accomplish the required goal and without unduly compromising your confidences or privacy.

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If you wish to restrict the use or disclosure of your private medical information, please request such a restriction in writing. I, Germaine Seufert and Consultants for Children, Inc., am not required by law to agree to such restrictions, but will make reasonable efforts to accommodate such requests. If I do honor a request to restrict disclosure of certain information, that restriction will be effective until revoked in writing by you.

Any other disclosures of medical information will be made only with your prior, specific written authorization. Such authorization may be revoked in writing prior to the disclosure of authorized information.

You may, at any time, make a written request for an accounting of disclosures of protected health information for the six years preceding the request or such lesser time requested. Such accounting will be provided within 60 days after receipt of the written request and will not include an accounting of disclosures made for purposes of treatment, payment or health care operations or status disclosures discussed above (such as mailing of appointment reminders). Such accounting will be provided one time per 12-month period without cost or fee. For additional requests within any 12-month period, a reasonable fee will be charged for the time and supplies required to fulfill the request.

Right to Inspect, Copy, or Amend Protected Health Information

You have the right to inspect and have copied, at your expense, your protected health information, with the exception of therapy notes, written request for as long as such records are maintained by me, Germaine Seufert and Consultants for Children, Inc.. You may also request a summary or explanation of information in lieu of actual inspection or copying. If you make such a request, you will be responsible for the reasonable costs to prepare the summary or explanation.

You may request in writing that protected information be amended. I, Germaine Seufert and Consultants for Children, Inc., will act upon this request within 60 days of receipt. I will not amend protected information that was not created by myself unless you provide a reasonable basis to believe that the originator is no longer available to act upon the request, is not part of the designated record set, is not available for inspection by law, or is accurate and complete.

Notice Requirements

I, Germaine Seufert, am required to abide by the terms of the notice currently in effect. I, Germaine Seufert, shall treat any and all protected health information in accordance with the notice currently in effect. I, Germaine Seufert, reserve the right to change the terms of this notice, in accordance with applicable laws, and to make such changes effective for all protected health information. Written notice of any such changes will be personally delivered to or mailed to you upon implementation

Emergencies

I do not have the same access as clinicians in agency settings. Therefore, in case of an emergency situation in which there is imminent concern regarding life and death, please call 911. In the case of any other clinical emergency/urgency, please call my voice mail (720) 272-1289 and leave a message as to where you can be reached. I will try to return your call regarding any clinically urgent matter the day I receive your message. If at any time we decide your needs have intensified and you require someone who is available 24-hours per day, I will refer you to an appropriate clinician and/or treatment agency.

If you are a parent seeking therapy for your minor child, your signature below authorized Germaine Seufert and Consultants for Children, Inc. to treat the following listed children:

Child's Name Child's Date of Birth

I have been informed of the license, degrees, and credentials of my therapist. I have also read the preceding information on the Disclosure Statement and Notice of Privacy Practices, understand my rights and responsibilities as a patient/client (or parent of a minor) and acknowledge receiving a copy of this form.

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Further, for clarification purposes, the boxes checked below indicate how I, the client/parent or guardian, am authorizing Germaine Seufert and Consultants for Children, Inc. to communicate information to me (initial the space provided in front of each permitted item):

Telephone

Voicemail messages are permitted

Speaking to other family members living in the home is permitted

Speaking to visiting relatives/friends who answer the phone is permitted

Fax

If I, the client, request information to be sent to a fax number, I take responsibility for the confidentiality of that faxed information once it is sent

Electronic Mail

Using electronic mail is permitted for the following reasons:

To schedule and confirm appointments

To ask and answer questions regarding behaviors/treatment recommendations/referrals/ suggestions, etc.

To send reports with client information in them

To send evaluations with client information in them

Please list any other restrictions here:

I may revoke this consent at any time in writing. If I do not revoke this consent, this consent will expire one year from today's date.

Signature of Patient, or if minor, parent/guardian Date

Signature of Germaine Seufert Date

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