COBYS Family Services
1417 Oregon Rd, Leola, PA 17540
Phone: 717-661-3548
Fax: 717-656-3056 · Web: www.cobys.org

Child Intake Information

Welcome to COBYS Family Services. We are pleased to have the opportunity to serve you. Please complete this form. The following information will assist the counselor and you to work together. This information is confidential and will not be shared without your permission.

Identified Client: _____ Date of Birth: _____ Male ☐ Female ☐

Email Address: _____ Home Telephone: _____ Cell Number:_____

Home Address: _____

Grade: _____ School: _____ Teacher: _____ Special Ed: Yes ☐ No ☐

If Yes, explain: _____

Family Members: (List names of household members; identified client first, adults, children)

Name	Relationship*	Birth Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Guardian: _____ * indicate relationship to head(s) of household (i.e. spouse, daughter, son, stepson, friend, etc.)

Religion/Church affiliation (place of worship/location/denomination): _____

What are some of your child's strengths? _____

Medical Information:

Does your child have any allergies, including allergies to medication? _____

Has your child ever received psychiatric or psychological help of any kind?

Yes ☐ No ☐ If Yes, please explain: _____

Have any family members ever received psychiatric or psychological help of any kind?

Yes ☐ No ☐ If Yes, please explain: _____

Physician's Name/Practice: _____Telephone Number _____

Address: _____

Other related providers: _____(psychiatrist, OT, PT, caseworker, etc.)

Do you give COBYS permission to contact your child's primary care physician concerning treatment? Yes ☐ No ☐

Signature (may sign electronically): _____

Referral Information (please check one from the list):

How did you learn about COBYS Family Services? Brochure/Flyer/Pamphlet ☐ Church ☐ Former Client ☐ Pastor ☐

Yellow Pages ☐ Newspaper ☐ Internet ☐ Friend/Family ☐ Other (please specify) _____

Who referred you for counseling services at the center?

_____

Briefly describe your reason for seeking help:

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Child History Form

Form Completed by: _____ Date Completed: _____

Relationship of Person Completing Form to Child/Adolescent: _____

Child's Name: _____ Date of Birth: _____ Male ☐ Female ☐

Lives with: _____ School: _____ Grade: _____ School District: _____

Has your child previously been diagnosed with any mental health condition? Yes ☐ No ☐ If yes, explain:

Pregnancy/Birth

Did mother use any of the following during pregnancy? Tobacco ☐ Alcohol ☐ Drugs ☐
Describe any difficulties during pregnancy:

Mothers' age at child's birth: _____ Length of pregnancy: _____ Birth Weight: _____

Vaginal or c-section delivery: _____

Describe any difficulties during delivery:

Were there any medical problems noted at or immediately following birth?

Developmental History of Child/Teen

Please state the age at which your child/teen did the following. If not certain, give the approximate age.
MOTOR: Sat alone:_____ Stood alone:_____ Walked alone:_____

LANGUAGE: Started using single words (other than "mama and "dada") _____ Used three-word sentences: _____
Please indicate any difficulties your child/teen has had with the following:

	In the Past	Currently	Never
Toileting	☐	☐	☐
Eating	☐	☐	☐
Sleeping	☐	☐	☐

Describe your child as an infant. Include temperament and/or relational aspects of infancy.

Physical: Check any of these pre- or post-natal problems that the child/adolescent experienced.

☐ Allergies	☐ Asthma	☐ Blueness	☐ Breathing difficulties
☐ Colic	☐ Feeding problems	☐ Frequent ear infections	☐ Hearing loss
☐ Irregular sleep habits	☐ Jaundice	☐ Over activity	☐ Poor vision
☐ Prolonged high fevers	☐ Seizures	☐ Speech problems	☐ Umbilical cord around neck

Other_____ Additional Comments: _____

List a psychotropic medications that your child is taking. Please provide at least a three-year history.

Medication	Dose/Frequency	When Started	For What Symptom(s)?

List other prescriptions/non-prescription medications that your child is takes (include herbal supplements and vitamins).

Medication	Dose/Frequency	When Started	For What Symptom(s)?

List any previous mental health or substance abuse treatment (include any inpatient or hospital treatment for a mental health or substance abuse disorder) that your child has had. (Substance abuse would include tobacco, alcohol and/or drugs)

Date of Treatment (approximate)	Name of Treatment Provider or Agency	What was your child's problem at the time?	Were your child's treatment goals met?

Was anything in the previous treatment particularly helpful? Not helpful?

Has your child been a victim of: sexual abuse ☐ , physical abuse ☐ , emotional abuse ☐ ? If yes, please explain.

Are you aware of and/or concerned about substance use/abuse (including tobacco, alcohol and/or drugs) of your child/teen? If so, please explain.

Family Stressors: Check any of these sources of family stress that apply to the child/adolescent's family

☐ financial stress	☐ recent move	☐ divorce/separation
☐ marital discord	☐ recent fire	☐ uninvolved or absent parent
☐ difficult children	☐ burglary/home break-in	☐ post divorce/co-parenting issues
☐ job loss/unemployment	☐ parent currently imprisoned	☐ overworked parent(s)
☐ changed schools recently	☐ assault	☐ deaths during past three years
☐ other trauma or loss	Comments: _____	

Family History: Parents' Marital Status: Married ☐ Separated ☐ Never married ☐ Divorced ☐ Other ☐

	Mother	Father
Name		
Birth Date/Age		
Education/Grade Completed		
Occupation		
Cultural Needs		
Past Mental Health Treatment		
Current Medications		
Past Medical History		
Drug or Alcohol History		
Learning Difficulties		
Abuse History		
Family Mental Health History (ADHD, depression, anxiety, suicide, etc.)		

Please describe your method of discipline.

Who cares for your child when she/he is not in your care? _____

Please provide child care history.

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Brief Notice of Privacy Practices (NPP)

This information is being provided to you as required by the Health Insurance Portability and Accountability Act of 1996. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

COBYS Family Services' commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This notice is a shorter version of the full version. It summarizes the main points of the policy. We are required to give every client of the counseling program a copy of the legally required NPP, which you received and for which you signed. However, we can't cover all possible situations so please talk to our Privacy Officer about any questions or problems.

Medical information refers to all the information that is gathered and kept on file in the course of your psychotherapy. We will use the information about your health which we obtain from you or from others to provide you with treatment, to arrange payment for our services, and for some other business activities which are called health care operations. After you have read this NPP, we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an authorization form to allow us to do that. Of course we will keep your health information private, but there are some times when the laws require us to use or share it.

For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will share information only with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires us to do so.

4. For Workers Compensation and similar benefit programs.

Other less common situations like these are described in the full NPP document.

Your rights regarding your health information:

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. Should we agree to honor your request, we do so unless it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you, such as your medical and billing records. You can even get a copy of these records, but we may charge you. Contact our Privacy Officer to arrange how to see your records or obtain a copy. (See below.)

4. If you believe the information in your records is incorrect or missing important information, you can ask us to amend your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us why you want to make the changes.

5. You have a right to a copy of this notice. If we change this NPP, we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the care we provide to you in any way.

If you have any questions regarding this notice or the privacy policies of COBYS Family Services, please contact our Privacy Officer:

Abby L. Keiser, MS, Director of Family Life Services
1417 Oregon Road, Leola, PA 17540
Phone: 717-661-3548
Email: counselingadmin@cobys.org

The full version of NPP will be provided upon request. The effective date of this notice is March 23, 2017.

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Consent to Use and Disclose Your Health Information Under the Health Insurance Portability and Accountability Act of 1996

This form is an agreement between you, _____, and COBYS Family Services. When we use the word "you" below, it will mean you or your child. Marital therapy clients both must sign an agreement. When we evaluate, diagnose, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We use this information to decide what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this consent form. If you do not sign this consent form, agreeing to what is in our Notice of Privacy Practices, we cannot offer psychotherapy/counseling to you. This is a provision of the Health Information Portability and Accountability Act of 1996, effective April 14, 2003.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our website, by calling us, or from our privacy officer. If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing.

Although we will try to respect your wishes, we are not required in every instance to agree to these limitations. However, if we do agree, we promise to comply with your wishes. After you have signed this consent, you have the right to revoke it by writing a letter telling us you no longer consent. We will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information.

_____ _____

Signature of client or parent/guardian of client Date

_____

Printed name of client or parent/guardian of client

_____ _____

Witness Signature Date

Date on which copy given to the client or parent/guardian _____

Privacy Officer: Abby L. Keiser M.S, Director of Family Life Services
COBYS Family Services is dedicated to the highest degree of confidentiality under the law.

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Client Information and Consent to Treatment

COBYS Family Services provides therapy to help clients with individual, marital, or family problems. Counseling is voluntary and will be provided without discrimination on the basis of race, sex, religion, ethnicity, national origin, marital status, handicap, sexual orientation, or age. If you need adjunctive mental health services beyond outpatient treatment, we are happy to refer to other treatment providers.

Fee and Payment Service

Psychotherapy fees are standard depending on the type and length of treatment session. Client fees are to be paid at each session by cash, check or credit card made payable to COBYS Family Services. Some of our therapists are on some insurance panels. For those situations we will submit your claims on your behalf. If we are out of network and you would like to use your insurance benefits, we will provide you the necessary documentation, but **you are responsible for determining if your health insurance covers the counseling services you are receiving**. If you have a change in insurance, you are responsible to report it immediately to prevent a lapse in services. You will be responsible for all fees if COBYS was not informed of insurance change. A sliding scale fee is available for those who do not have insurance. Your therapist will determine the fee during the first session.

In addition to therapeutic session fees, we charge for other professional services you may need including report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if we are called to testify by another party.

Appointments and Cancellations

All appointments and the cancellations of appointments are made directly with the COBYS therapist or counseling secretary by calling 717-661-3548 between 8:30 a.m. and 4:30 p.m. **Your full fee will be charged for no-shows or cancellations made with less than 24 hours notice.**

Emergencies

For life threatening emergencies, dial 911. COBYS does not provide crisis or emergency service. In the case of an emergency, please call your county crisis unit or go to your local Emergency Room. Lancaster Crisis Intervention Unit: **717-394-2631.** Lebanon Crisis Intervention Unit: **717-274-3363.**

Confidentiality

While receiving service from this agency, you shall retain all rights of confidentiality, except where restricted by law. Any child or adolescent under the age of 18, unless legally emancipated or graduated from high school, will be treated only with the full knowledge and approval of that individual's parent, guardian, and/or primary caregiver.

All verbal and written material shared between you and your therapist will be kept strictly confidential, with these exceptions: A) Information for which you give informed written consent to release; B) Issues involving concern about your own or someone else's physical safety; C) Information regarding abuse of a minor or elder; D) Court orders; and E) Supervision, consultation, and/or professional training of your therapist. All professionals also are bound to the laws of confidentiality. Every effort is made to reveal only necessary information. COBYS Family Services is compliant with the Federal Health Insurance Portability and Accountability Act (HIPAA) regarding confidentiality.

If COBYS and its staff have reason to suspect that a child is or has been abused and/or neglected, we are required to report our suspicions to the appropriate authorities. We are required to make such reports even ***if we do not see the child in a professional capacity.*** COBYS and its staff are mandated to report suspected child abuse if anyone aged 14 or older tells us that he or she committed child abuse, even if the victim is no longer in danger. We are also mandated to report suspected child abuse if anyone tells us that he or she knows of any child who is currently being abused.

Special Considerations Regarding Children

At COBYS we work with children within the context of their family system. We ask that both parents consent to treatment regardless of parent separation or divorce, except in unusual circumstances which can be discussed with your therapist. We encourage all parents to be involved in treatment of your child. Our role as your child's therapist is limited to only providing treatment, and we are ethically bound to refrain from making recommendations concerning custody or visitation arrangements.

Notification of Referring Person

We believe that most people function within a community. For this reason, if you have been referred to COBYS Family Services by a professional, such as a pastor, physician, therapist, social worker, etc., it may be helpful for us to collaborate with them. We will do so only with your written permission.

Weapons Policy

Consistent with COBYS Employee Policy regarding weapons and firearms, no weapons are permitted on COBYS property including in vehicles on the parking lot or in your possession. Weapons include any object that would typically be considered a weapon and other objects if they are used in a weapon-like manner. Pocket knives used only for typical utility purposes and pepper spray intended for personal protection will not be considered weapons, if used and stored properly.

Release of Information to Insurance Company and Benefits Assignment for Claims

By signing this form, you consent for COBYS to release information to and bill your health insurance company, and for your insurance company to make payments directly to COBYS.

Termination or Transfer of Service

You may discontinue treatment at any time. We request that therapy be terminated in a final face-to-face termination session with your therapist, rather than by phone or mail.

Concerns

COBYS encourages you to share concerns or suggestions about the quality of your treatment with your therapist. In case of a grievance that cannot be resolved between the therapist and the client/family, the client(s) may discuss the concern by phone, in writing, or in person with the Supervisor of Counseling Services. If this is unsatisfactory, you may contact the Executive Director, COBYS Family Services, 1417 Oregon Road, Leola, PA 17540

I signify that I have received the above information. I agree to these policies and want to join the therapeutic relationship for treatment services.

_____		_____	
Client Signature	Date	Parent/Guardian Signature	Date
_____		_____	
Therapist Signature	Date	Counseling Location	

Application for Compassion Care Fund

The fee for psychotherapy services at COBYS is $120 per session. You may be eligible for our **Compassionate Care Fund,** which is provided by private donations from individuals, churches, and others. If you feel this would be applicable, please complete income information below. If you need assistance, call the counseling program administrative assistant at 717-661-3548 or 1-800-452-6517.

*Please bring verification of the income to first session (i.e., payroll stub, income tax form, etc.) or the full fee will be charged.

Income Information

COMBINED GROSS INCOME OF HOUSEHOLD MEMBERS				
NAMES OF ALL ADULTS IN HOUSEHOLD	EARNINGS FROM EMPLOYMENT	NON-EMPLOYMENT INCOME	SOCIAL SECURITY PENSIONS, RETIREMENT, DISABILITY INCOME	TOTAL OF EACH LINE
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$
COMBINED YEARLY ☐ MONTHLY ☐ INCOME (check which one used)				$

Client complete form to this line.

Fee Payment Agreement (to be completed with counselor):

_____ I (We) agree to pay the full cost of $130 for the initial intake session.
_____ I (We) agree to pay the full cost of each session.
$120 per 1 hour session or $95 per 45 minutes session.
_____I (We) want to participate in counseling; however, the cost is a financial hardship for myself/family. I (We) agree to pay a fee based on my (our) income using the Compassionate Care Fund. I (We) certify that the household income information provided above is true and correct and that all income was reported. The income information is being given so a fee can be determined.

My (Our) fee is $_____ per counseling session (45 min.). I (We) understand that $_____ will be paid on my (our) behalf from the Compassionate Care Fund.

_____A third party/church/insurance company will pay all or a portion of my (our) fee. Name and address of third party (church, family, agency, or insurance company) is

_____

My (Our) part: $_____ Third party: $_____ *I (We) understand that I (we) am ultimately responsible for my fee

I understand how the counseling fee has been determined and the terms of payment. Payment is expected at time of service.

Signature: _____ Date: _____
Therapist Signature: _____ Date: _____

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Permission to Record Sessions and Present in Supervision

I hereby give permission to my therapist to audio/video record any and all sessions for the purpose of supervision and instruction. I give permission to my therapist to present my case to his/her supervisor and/or group supervisor.

I understand that those parties who hear, see, or have my case presented to them (psychologists, social workers, psychotherapists, family therapists) are bound by their professional ethics of confidentiality.

I understand that, at the end of each session, I have the right to refuse to have any recording used for such purpose and that the erasing/destruction of the recording will take place in my presence.

This agreement is valid from this date of execution to the termination of my therapy.

I agree to the stipulations as they are stated in this agreement.

Client's Name (Printed) _____ Client's Signature: _____

Parent/Guardian Signature _____

Therapist's Signature: _____ Date: _____

I agree to the stipulations as they are stated in the agreement with the following exceptions or additions:

Client's Name (Printed) _____ Client's Signature: _____

Therapist's Signature: _____ Date: _____

COBYS Family Services Photo Release Form

COBYS Family Services occasionally takes photos of our Family Life Education programs to use for promotional purposes. We are seeking your permission to use photos of you and your family. Please initial each statement that applies to you, sign the form, and return to a COBYS educator.

_____ I grant COBYS Family Services permission to use photographs of me and my family in whole or in part, alone or in conjunction with other photographs, in promotional material that is distributed to the public as a representation of COBYS programs. "Promotional materials" may include newsletters, brochures, newspaper advertisements, promotional slide shows, display boards, website/Facebook, and other uses.

_____ I grant COBYS Family Services permission as described above with these exceptions:

_____

I have read and understood the terms above and hereby grant my consent for the use of photographs of my family as indicated above.

Name: _____

Signature: _____ Date: _____

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Collaboration with Existing Mental Health Providers

Dear Parent/Caregiver,

In order to ensure best clinical practice and proper insurance authorization, COBYS Family Services requires notification if your child is receiving additional mental health treatment. Furthermore, if your child is receiving a higher level of mental health care, we require a recommendation from your child's mental health provider prior to participation in the program. Examples of a higher level of care include but are not limited to Behavioral Health Rehabilitation Services (Behavioral Specialist Consultant, Mobile Therapist, Therapeutic Support Staff), Intensive Day Programs, and Family-Based Services. Please complete the following:

1. On the release of information for your child's mental health provider, write the name of the mental health provider, provide contact information, and sign where it states parent/guardian signature.
2. Have your child's mental health provider complete the Recommendation for Participation in the Dina Program. The mental health provider should then return the recommendation to COBYS.

Your child's position in the program will not be secured until this form is returned. While this recommendation will be very helpful, your COBYS intake therapist retains the right to make the final decision regarding the appropriateness of the program.

During the course of treatment, it may be beneficial for COBYS Family Services to continue collaboration with your child's existing mental health treatment team. Your child's Dina therapist will contact you regarding the necessity of this collaboration. Thank you for your understanding and cooperation with these procedures. We look forward to serving you, your child, and your family.

Sincerely,

Roseauna G. Good, LPC

Roseauna G. Good, LPC
Dina Clinical Coordinator
COBYS Family Services

Enclosures (2)
Authorization to Release Protected Healthcare Information
Recommendation for Participation in the Dina Program

COBYS Family Services
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Fax: 717-656-3056 · Web: www.cobys.org

Authorization to Use and Disclose Protected Health Information

1. Client's Printed Name: _____ Date of Birth: _____

2. I authorize COBYS Family Services to receive or disclose the following information:

- ☐ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse.
- ☐ Admission and discharge summaries.
- ☐ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- ☐ Treatment, recovery, rehabilitation, aftercare plans, and other similar plans
- ☐ Social, family, educational, and vocational histories.
- ☐ Social work assessments and plans.
- ☐ Progress, nursing, care, or similar notes.
- ☐ Evaluations and reports of consultants.
- ☐ Information about how the patient's condition or conditions affect or have affected his or her ability to work, and to complete tasks or activities of daily living.
- ☐ Vocational evaluations and reports.
- ☐ Billing records.
- ☐ Academic and educational records, including achievement test and other test results, reports of teachers' observations, and all other school or special education documents.
- ☐ Complete copy of the medical record.

Other: _____

3. To **this mental health provider: Agency: _____**

Address: _____
Phone: _____ Fax: _____

I understand and agree that this Authorization will be valid and in effect until I am no longer a client of COBYS Family Services. I also understand that I can revoke or cancel this authorization at any time by notifying the Privacy Officer in writing. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

_____ _____
Signature of Client (If age 12 or older) Date

_____ _____
Signature of Parent/Guardian/Responsible Party Date

_____ _____ _____
Signature of Witness Title Date

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Recommendation for Participation in the Dina Program

Dear Mental Health Provider,

The parent/guardian of _____, date of birth _____,
(full name of child)
would like to enroll this child in the Dina Small Group Therapy Program provided by COBYS Family Services. The program consists of eighteen 2-hour sessions with approximately eight 4-8 year old children supported by approximately three adults. Children will learn valuable skills like following rules, emotional identification, problem solving, anger management, and positive peer interactions through modalities such as coached play, psychoeducation, role play, videos, games, crafts, bibliotherapy, and puppets. As this child's treating mental health clinician, COBYS Family Services believes you have great insight into the capabilities of this child, and therefore requires your recommendation prior to this child's enrollment in the program. We have determined that children with the following abilities have been most successful in the Dina program:

- The ability to interact with peers in a safe manner with little to no aggressive or destructive tendencies.
- The ability to sit and remain focused on content for periods of at least 5 minutes.
- The ability to derive meaning from social interactions.
- The ability to be successful without constant one-on-one support.

Please indicate your type of recommendation below:

I recommend this child participate in the Dina Small Group Therapy Program with no concerns.

I recommend this child participate in the Dina Small Group Therapy Program with the following concerns:

_____

I recommend this child does not participate in the Dina Small Group Therapy Program due to these concerns:

_____

I wish to talk further with the intake therapist. I have provided my contact information below.

Please return this completed form to COBYS Family Services, ATTN: Rosie Good, LPC at 1417 Oregon Rd, Leola, PA 17540 or fax to 717-656-3056 as soon as possible or the child's participation in the program may be delayed.

Thank you for your time and assistance with this matter. Feel free to contact COBYS Family Services at 717-661-3548 if you would like to speak further. We have secured a signed release from the parent/guardian of this child allowing us to collaborate as necessary.

Clinician Name: _____ Title: _____

Agency: _____ Phone: _____

E-mail: _____

Clinician Signature: _____ Date: _____

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Authorization to Use and Disclose Protected Health Information

1. Client's Printed Name: _____ Date of Birth: _____

2. I authorize COBYS Family Services to receive or disclose the following information:

- ☐ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse.
- ☐ Admission and discharge summaries.
- ☐ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents. Treatment, recovery, rehabilitation, aftercare plans, and other similar plans
- ☐ Social, family, educational, and vocational histories.
- ☐ Social work assessments and plans.
- ☐ Progress, nursing, care, or similar notes.
- ☐ Evaluations and reports of consultants.
- ☐ Information about how the patient's condition or conditions affect or have affected his or her ability to work, and to complete tasks or activities of daily living.
- ☐ Vocational evaluations and reports.
- ☐ Billing records.
- ☐ Academic and educational records, including achievement test and other test results, reports of teachers' observations, and all other school or special education documents.
- ☐ Complete copy of the medical record.

Other: _____

3. To **this school district:** _____

Address: _____
Phone: _____ Fax: _____

4. I authorize the Dina therapist to share the information about the client's progress in Dina with the client's school teacher and/or guidance counselor.
Teacher's Name: _____ Position: _____
Teacher's Contact Phone/Email: _____

I understand and agree that this Authorization will be valid and in effect until I am no longer a client of COBYS Family Services. I also understand that I can revoke or cancel this authorization at any time by notifying the Privacy Officer in writing. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

_____ _____
Signature of Client (If age 12 or older) Date

_____ _____
Signature of Parent/Guardian/Responsible Party Date

_____ _____ _____
Signature of Witness Title Date

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1417 Oregon Rd., Leola, PA 17540
Phone: 717-661-3548
Fax: 717-656-3056 · Web: www.cobys.org

Authorization to Use and Disclose Protected Health Information

1. Client's Printed Name: _____ Date of Birth: _____

2. I authorize COBYS Family Services to receive or disclose the following information:

- ☐ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse.
- ☐ Admission and discharge summaries.
- ☐ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- ☐ Treatment, recovery, rehabilitation, aftercare plans, and other similar plans
- ☐ Social, family, educational, and vocational histories.
- ☐ Social work assessments and plans.
- ☐ Progress, nursing, care, or similar notes.
- ☐ Evaluations and reports of consultants.
- ☐ Information about how the patient's condition or conditions affect or have affected his or her ability to work, and to complete tasks or activities of daily living.
- ☐ Vocational evaluations and reports.
- ☐ Billing records.
- ☐ Academic and educational records, including achievement test and other test results, reports of teachers' observations, and all other school or special education documents.
- ☐ Complete copy of the medical record.

Other: _____

3. To **COBYS Family Services**
Address: _____
Phone: _____ Fax: _____

I understand and agree that this Authorization will be valid and in effect until I am no longer a client of COBYS Family Services. I also understand that I can revoke or cancel this authorization at any time by notifying the Privacy Officer in writing. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

_____ _____
Signature of Client (If age 12 or older) Date

_____ _____
Signature of Parent/Guardian/Responsible Party Date

_____ _____ _____
Signature of Witness Title Date

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☐ Billing records.

☐ Academic and educational records, including achievement test and other test results, reports of teachers' observations, and all other school or special education documents.

☐ Complete copy of the medical record.

Other: _____

3. To **this primary care physician: Office:** _____

Address: _____
Phone: _____ Fax: _____

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_____ _____
Signature of Parent/Guardian/Responsible Party Date

_____ _____ _____
Signature of Witness Title Date

Appointment Reminders Authorization Form and Other Forms of Communication

COBYS now offers appointment reminders to our clients by email, text message, and/or automated phone calls. Appointment reminders are for your convenience only. Our cancellation policy and fees still apply. For DINA Small Group Therapy, it is important to note if texting is allowed between the therapist and the parent/guardian, the text may not be secured. By signing that texting is allowed, you recognize the text may be unsecured with the information between the therapist and parent/guardian.

About Email Reminders
Automated email reminders are sent between 60 and 20 hours in advance of the appointment.

About Text Message (SMS) Reminders
Automated text (SMS) reminders are sent between 24 and 2 hours in advance of the appointment, between 8AM and 9PM. Only mobile phones can receive text message reminders. To opt out of text appointment reminders, reply "STOP" to the message.

About Phone Call Reminders
Automated phone call reminders are sent between 24 and 2 hours in advance of the appointment, between 8AM and 9PM. Home or mobile phones can receive voice message reminders. If you do not answer, the automated service leaves a voicemail and repeats the following message twice: "This call is to remind you about your appointment <day> at <time> with COBYS Family Services. Please call our offices at 717-661-3548 if you have any questions or will not be able to attend. If you would like to disable appointment reminders by telephone, please talk to your clinician." These calls will come from a 215 area code.

Select one:

☐ **Email Only**
Use this email address: _____

☐ **Text (SMS) Only**
Use this mobile number: _____

☐ **Text (SMS) and Email**
Use this mobile number: _____

And use this email address: _____

☐ **Text or Automated Phone Call, and Email**
Use this mobile or home number: _____

And use this email address: _____

☐ **Text or Automated Call only**
Use this mobile or home number: _____

☐ **No reminders**

_____ _____
Signature **Date**

_____ _____
Name of Client (please print) **Client's Date of Birth**

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INFORMED CONSENT FOR TELETHERAPY

COBYS FAMILY SERVICES COUNSELING DEPARTMENT

This Informed Consent for Teletherapy contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let us know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Teletherapy

Teletherapy refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of Teletherapy is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of in these challenging times. Teletherapy, however, requires technical competence on both our parts to be helpful. Although there are benefits of Teletherapy, there are some differences between in-person psychotherapy and Teletherapy, as well as some risks. For example:

- Risks to confidentiality. Because Teletherapy sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On our end, therapists will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for teletherapy sessions where you will not be interrupted. It is also important for you to protect the privacy of your session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact Teletherapy. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, a therapist will not engage in Teletherapy with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in Teletherapy, you and your therapist will develop an emergency response plan to address potential crisis situations that may arise during the course of our Teletherapy work.

- Efficacy. Most research shows that Teletherapy is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications
Your therapist and you will decide together which kind of Teletherapy service to use. You may have to have certain computer or cell phone systems to use Teletherapy services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in Teletherapy.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach your therapist by phone. Your therapist will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach your therapist and feel that you cannot wait for them to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

Confidentiality
We have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our Teletherapy. However, the nature of electronic communications technologies is such that we cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. We will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for Teletherapy sessions and having passwords to protect the device you use for Teletherapy).

The extent of confidentiality and the exceptions to confidentiality that we outlined in the original ***Client Information and Consent to Treatment*** still apply in Teletherapy. Please let us know if you have any questions about exceptions to confidentiality.

Emergencies and Technology
Assessing and evaluating threats and other emergencies can be more difficult when conducting Teletherapy than in traditional in-person therapy. To address some of these difficulties, please refer to your Wellness Plan. We ask you to identify an emergency contact person who is near your location and who your therapist will contact in the event of a crisis or emergency to assist in addressing the situation.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call your therapist back; instead, call 911 or Crisis Intervention at 717.394.2631 or go to your nearest emergency room. Call your therapist back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and your therapist will contact you within two (2) minutes via the VSee platform on which we agreed to conduct therapy. If you are unable to connect through VSee, your therapist will call you individually on the number you previously provided.

If there is a technological failure and we are unable to resume the connection, we will only charge you for the actual session time.

Fees

The same fee rates will apply for Teletherapy as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in Teletherapy sessions in order to determine whether these sessions will be covered.

Records

The Teletherapy sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

_____ _____

Client Date

_____ _____

Therapist Date

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www.cobys.org

Authorization Agreement for Credit Card Payment for Counseling Services

For payment to COBYS Family Services via your credit card account, simply complete and sign the form below. Your payment will appear on your statement.

Name Printed on Credit Card _____

Card Account Mailing Address _____

City _____ State _____ Zip Code _____

E-mail Address _____ Telephone _____

USE FOR RECURRING CHARGES ONLY

I understand that my credit card account will be charged in the amount of $_____ immediately after each session.

I also understand that my credit card account will be automatically charged for any unpaid balances, including session fees, co-payments, deductibles, coinsurance, and failed appointment and late cancellation charges.

Please tell us how long you want us to automatically bill your credit card:

☐ This authorization is valid until I provide you with written cancellation.
☐ This authorization is valid until _____

USE FOR ONE TIME CHARGES

☐ **I understand that my credit card account will be charged in the amount of $_____ for a one time only charge.**

☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **American Express**

Account number: _____ CVV Number: _____ Expiration Date: _____

I hereby authorize COBYS Family Services to charge my credit card as designated above.

Signature _____ Date _____

You may cancel this automatic billing authorization at any time by contacting us in writing at COBYS Family Services, 1417 Oregon Road, Leola, PA 17540. For questions, contact Counseling Administrative Assistant Sheila Thum at 717-661-3548 or sthum@cobys.org

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PerformCare Provider Choice

The purpose of this form is to inform you that, as a PerformCare member, you have choices regarding your healthcare provider.

You can choose your provider.
For each level of care, there are providers available for you to choose from.
You can choose a provider that is close to you.
You can choose a provider that offers the care you need.
You can choose a provider who can relate to you, speak your language, or provide needed interpretation for you.
If you are not happy with a provider, you can choose a different provider.
PerformCare members can request appointments at times that are convenient for them.
Providers also will talk with you about choices you have.

Call PerformCare at 1-888-722-8646 for provider information, or you can access a provider directory at www.performcare.org.

Appointments and Cancellation Policy
All appointments and the cancellations of appointments are made directly with the COBYS therapist or counseling Administrative Assistant by calling 717-661-3548 between 8:30 a.m. and 4:30 p.m. We honor your appointment time. A 24-hour notice to cancel an appointment is expected. You will be discharged from treatment after two no-shows or cancellations made with less than 24 hours notice.

I have read and/or have had the contents of this form explained to me and understand my rights with regard to provider choice.

Signature_____ Date_____
(Adult over 18 years of age)

Signature_____ Date_____
(Adult over 18 years of age)

Signature_____ Date_____
(Minor over 14 years of age)

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Where You Can Find Us

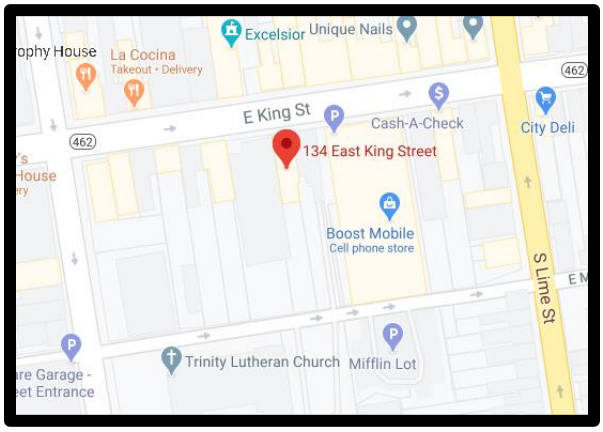
Oregon Counseling Center, 1417 Oregon Rd. Leola, PA 17540

The Oregon Counseling Center at COBYS Family Services main office, in the historic Oregon Mill, near Oregon Dairy and Reflections restaurant.

From Ephrata: Exit Rt. 222 South at Oregon Pike exit. At the end of ramp, turn right onto Oregon Pike/Rt. 272 North. Follow directions below.

From Lancaster: Exit Rt. 222 North at Oregon Pike exit. Turn left at the end of the ramp onto Butter Road., and immediately left again onto Jake Landis Rd. Turn right at light onto Oregon Pike/Rt. 272 North. Follow directions below.

From Oregon Pike/272 N., take next left onto Creek Rd. Turn right at stop sign onto Oregon Rd./Rt 722 W. Cross bridge and enter driveway on right.



Lancaster Counseling Center

134 E. King St., Lancaster, PA 17602

From Ephrata: Get on US-222 S in West Earl Township. Continue on US-222 S to Lancaster. Take the PA-23 W/Walnut St. exit from US-30 E. Continue on PA-23/W E Walnut St. Drive to E. King St.

From Oregon Pike: Get on US-222 S from PA-272 N. Continue on US-222 S to N. Duke St. Continue on N. Duke St. Drive to E. King St.

Parking Options:
1. Use the parking app on your smart phone, Park Mobile, to park in front of the building
2. Use King Street Garage next to the building

Palmyra Area Counseling Center

520 E. Birch St., Palmyra, PA 17078

The Palmyra Area Counseling Center is located in the Palmyra First United Methodist Church, between East Birch and East Elm Streets. Traveling East on Route-422, turn right at light onto Forge Street/Rt. 117 South (Klick-Lewis and Rite Aid on the corners). Go six blocks and turn right onto Birch Street. Go one block and turn left onto Green Street. (Church is on right after turn). Park on the street. When facing the church from Green Street, entrance is on the far left with separate sidewalk to entrance.