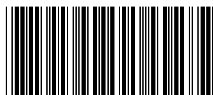


CONSENT
EX0132-003NS Rev. 6/2025

CHILDREN'S HEALTH

Informed Consent for Psychotherapy and Consultation Services Provided through the Texas Child Health Access Through Telemedicine (TCHATT Initiative)

Place a patient label on all sheets

Location: ______________________

Patient Name: * ______________________

DOB: * ______________________

Medical Record Number: ______________________

CSN: ______________________

Patient Name: * ______________________ Date of Birth: * ______________________

School Name: * ______________________ School District: * ______________________

School Counselor Name: * ______________________

I am the patient (or the parent / legal guardian of the patient), who will receive brief intervention services from the clinical team through the Texas Child Health Access Through Telemedicine (TCHATT) initiative. The clinical team may include my or my child's: 1) treating therapist, 2) psychologist(s), 3) clinical leadership, 4) case manager, 5) other medical providers including advanced practice provider, psychiatrists, and 6) trainees of all provider types listed herein involved with the TCHATT initiative.

I understand TCHATT services are fully funded by the Texas Child Mental Health Care Consortium, and I or my child will not be responsible for payment for TCHATT services rendered to me or my child. However, if the TCHATT team refers me or my child to community-based services which I or my child receives, I may incur a financial obligation for those services rendered and will be responsible for payment to those service providers.

I understand that the number of services and the nature of the intervention provided is solely up to the professional discretion of the TCHATT clinical team.

I understand the care the TCHATT clinical team provides is time-limited, brief intervention.

I understand that the purpose of the intervention sessions is limited to behavioral health / psychiatry assessment, short-term treatment which may include prescribing of medication (medication management will require a separate consent), case management and or / consulting services.

I understand that the care and evaluation provided through TCHATT services are only available through a telehealth platform and that no in-person services will be provided.

I understand as the parent or legal guardian, I am expected to be present at the initial evaluation at the same location as my child, either at home or at school.

I understand I am expected to be an active participant in my or my child's care which will include being present for follow-up therapy sessions and / or follow-up phone calls with the therapist, as determined by my or my child's treating therapist.

I understand the therapist working with me or my child may make a recommendation for consultation with a TCHATT child psychiatrist. If I, as the parent or legal guardian choose to participate in that evaluation with my child, I understand the following:

- I, as the caregiver, must be present with my child for the consultation.
- The evaluation will be a one-time consultation only.
- The consulting psychiatrist will not prescribe medications for my child. However, the consulting psychiatrist may recommend medication as a modality for care and will discuss those options with me as needed.
- The consulting psychiatrist will not provide ongoing psychiatric care and will be not be available for further consultation.
- Based on the results of the consultation, the TCHATT clinical team may attempt to connect with my child's primary care provider and / or refer my child to a community psychiatrist for ongoing psychiatric care as needed.

I understand that if at any point the TCHATT clinical team does not believe telehealth is a safe or clinically appropriate modality to deliver services to me or my child, they will make a recommendation for in-person services to be provided by another community provider or agency.

I understand that if I, or my child, is a danger to themselves or others and in need of emergent psychiatric care, I should follow emergency procedures including calling 911, and that TCHATT does not provide crisis or emergency services.

I understand that if I or my child has a mental health or other emergency prior to my or my child's next appointment with my or my child's treating TCHATT clinician, I should notify my or my child's treating TCHATT clinician and / or follow emergency procedures.

Patient / Legally Authorized Representative (signature required):

X ______________________ X ______________ ______________
Signature of Patient / Legally Authorized Representative | Date | Time

X ______________________ X ______________________
Printed Name of Patient / Legally Authorized Representative | Relationship to Patient

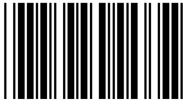
Signature of Witness | Credentials | Printed Name of Witness | Date | Time

Signature of Interpreter | Credentials | Printed Name of Interpreter | Date | Time

If telephone / virtual translation, name of Interpreter, ID number and Translation Services vendor

Signature of Provider Obtaining Consent | Credentials | Date | Time

Printed Name of Provider Obtaining Consent



AIS
CMC72047-002NS Rev. 8/2021

CHILDREN'S HEALTH

Behavioral Health Demographics Patient Information Form

PATIENT INFORMATION

*Child's Last Name: First: Middle:
*Phone number:

*Date of Birth (MM/DD/YY):
*Sex at Birth: ☐ Female ☐ Male ☐ Unknown
*Grade Level:

Preferred First Name:
Gender Identity: ☐ Female ☐ Male ☐ Non-Binary ☐ Not Listed ☐ Undetermined ☐ Chose not to disclose (decline)

Pronoun: ☐ He ☐ She ☐ They ☐ Name ☐ Decline ☐ Unknown ☐ Not Listed

*Child Lives With: ☐ Parent(s) ☐ Guardian(s) ☐ Other
*Relationship

*Child's Street Address: City: State: Zip:

Pediatrician's Name:
Phone Number:

Child's Preferred Language: Spoken: Written:
Interpreter Needed: ☐ Yes ☐ No

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Patient Refused ☐ Unknown

Race: ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian and Other Pacific Islander ☐ Other ☐ Patient Refused ☐ White or Caucasian

*Parent / Guardian Preferred Language: Spoken: Written:
Interpreter Needed: ☐ Yes ☐ No

PARENT / GUARDIAN INFORMATION

Parent / Guardian #1 Last Name: First:* Middle:
Relationship:

Parent / Guardian #1 Phone Number:
Parent / Guardian #1* Date of Birth:
Alternate Phone Number:

*Parent / Guardian #2 Last Name: First: Middle:
*Relationship:

*Parent / Guardian #2 Phone Number:
Parent / Guardian #2 Date of Birth:
Alternate Phone Number:

Primary Email: *
Alternate Email:
Opt out of E-Mails? ☐ Yes ☐ No

TCHATT services are provided at NO Cost

INSURANCE INFORMATION

Provide insurance information to help locate resources

Is patient covered by insurance? ☐ Yes ☐ No
Is patient covered by Medicaid? ☐ Yes ☐ No

Last Name of person responsible for paying the bill: First: Middle:
Relationship:

Billing Street Address: City: State: Zip: ☐ Same as Child ☐ Other

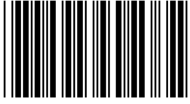
Insurance Policy Holder's Last Name: First: Middle:
Date of Birth (MM/DD/YY):

Employer:

Insurance Name:
Phone Number:

Insurance ID:
Group Number:

CHILDREN'S HEALTH



ROIF
EX0209-001NS Rev. 7/2024

Authorization for the Use, Disclosure and Release of Health Information to Schools

Place a patient label on all sheets

Location: ______________________

Patient Name: ______________________ Required

DOB: ______________________ Required

Medical Record Number: ______________________

CSN: ______________________

Communication with your child's school and / or athletic program is important when coordinating treatment and appropriate return to school and / or athletic program activities.

This authorization allows us to communicate directly with official representatives from your child's school / school district / and / or athletic program. All parties recognize and agree that the school / school district / school counselor and / or athletic program may also communicate (including in person, via telephone or encrypted email) information related to the patient back to Children's Health (as defined below).

I certify that I am the patient or legally authorized representative of: ______________________ (Patient's name) ("patient") and I hereby authorize Children's Health System of Texas ("Children's Health") and its representatives to release the patient's health information to the school / school district / school counselor and / or athletic program as follows:

HEALTH INFORMATION AUTHORIZED FOR RELEASE: Plan of care and any restrictions or other support related to the medical, psychiatric or mental health condition(s) being treated by the Children's Health care team.

Children's Health is hereby released from legal responsibility or liability for the disclosure of the records to the extent indicated and authorized herein. I also understand that I may revoke this authorization in writing at any time (except to the extent that action has been taken in reliance on this authorization) by sending a written notice to ATTN: Director Health Information Management Department, Children's Health, 1935 Medical District Drive, Dallas, Texas 75235.

Unless otherwise revoked, this authorization will expire one year from the date of my signature.

I understand that Children's Health will not base the plan of care, treatment, payment, enrollment or eligibility for benefits based on my completion of this authorization form.

The purpose of this consent form is to verbally communicate with your child's school counselor regarding referral updates & coordinating appointments. Your child's records will NOT be released.

I understand that the health record may contain information in reference to drug / alcohol abuse, psychiatric or mental health conditions, HIV / AIDS, intellectual disability or genetic testing. ☐ **I agree** _________ (initial) / ☐ **I disagree** _________ (initial) **to its release.** Required

I understand that this health information may no longer be protected by federal and state privacy laws once it is disclosed, and, therefore, may be subject to re-disclosure by the recipient.

PLEASE CHECK THE APPROPRIATE BOX BELOW: Required

☐ I agree to and authorize the release of the patient's health information.

☐ I do not agree or authorize the release of the patient's health information.

Health Information and plan of care related to the patient's medical condition(s) may be disclosed to official representatives (including, but not limited to, school nurses, teachers, school counselors, athletic coaches, athletic trainers, and academic advisors) at the following school / school district / athletic program / institution:

Name of Individual, or School, School district / Athletic program / Institution:

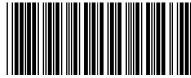
______________________ (school counselor's name & school campus name)

Address: ______________________ Telephone number: ______________________

E-mail: ______________________ Fax number: ______________________

X ______________________ X ______________ ______________
Signature of Patient or Legally Authorized Representative | Date | Time

X ______________________ X ______________________
Printed Name of Patient or Legally Authorized Representative | Relationship to Patient



CONSENT
CMC1019-017NS Rev. 8/2022

CHILDREN'S HEALTH SYSTEM OF TEXAS

General Consent for Treatment and Acknowledgements

Consent for Care

General Consent: I consent for the Patient, which may be defined as me, my child or a child for whom I have legal responsibility, to receive medical care and treatment as an outpatient or inpatient, depending on the Patient's medical needs, at a Children's Health System of Texas hospital, facility, entity or program (all referred to as **"Children's Health"**). Care and treatment may be provided by physicians, nurses, and other health care providers and employees. Care and treatment may include laboratory, radiology and other testing; evaluation and routine medical, surgical, nursing, psychiatric, psychological, mental / behavioral health / counseling, and other patient care, therapies and procedures. I agree that photos or video of the Patient may be taken in connection with such treatment and for operational, quality improvement, research, and education purposes. I understand that Children's Health is a teaching institution and agree that fellows, residents, trainees, students and other approved individuals may observe and participate in the Patient's care and treatment under appropriate supervision.

Independent Physicians / Dentists / Providers: Treating physicians and dentists at a Children's Health hospital / facility are not employees of the Children's Health hospital / facility. The physicians / dentists may be employed by other entities or be independent providers (collectively referred to as "Independent Providers"). There may also be advanced practice nurses, physician assistants and other health care providers that are Independent Providers and are not employed by Children's Health who treat the Patient at Children's Health. Independent Providers are responsible for their judgment, conduct and the medical / dental / mental / behavioral health care they provide. I acknowledge that Children's Health does not practice medicine and is not responsible for the judgment, conduct or care provided by Independent Providers.

Telemedicine / Virtual Visit Care: I agree that care may include evaluation, diagnosis, consultation on, and treatment of the Patient's medical or health condition using advanced telecommunications technology ("Telemedicine Services"; may also be referred to as "Virtual Visit Care"). I understand that Telemedicine Services include interactive audio, video or other electronic media and that there are both risks and benefits to being treated via telemedicine. Telemedicine providers (i) may be in a location other than where the Patient is located, (ii) will examine the Patient face-to-face via a remote presence but will not perform a "hands-on" physical examination, and (iii) must rely on information provided by the Patient and any on-site health care provider(s). Telemedicine Services may be limited or unavailable as a result of technological or equipment failures, incomplete or inaccurate data, or distortions of images or other information from electronic transmissions. I acknowledge that the Children's Health and telemedicine providers cannot be held liable for advice, recommendations and / or decisions based on factors not within their control, such as incomplete or inaccurate data provided by the Patient / others or distortions of diagnostic images or specimens that may result from electronic transmission.

If telemedicine providers determine that Telemedicine Services do not adequately address the Patient's medical needs, the Patient will be referred for on-site medical evaluation. If the Patient's condition is urgent / emergent, or if the telemedicine session is interrupted due to a technological or equipment failure, I agree the Patient will obtain follow up care and treatment as needed. I understand precautions are taken to protect the confidentiality of the Patient's medical information from unauthorized disclosure; however, I understand and acknowledge that the security of electronic transmission of data, video images, and audio information cannot be guaranteed and confidentiality may be compromised by illegal or improper tampering.

Medications / Treatments: Certain drugs and treatments recommended for the Patient by the Patient's physician, dentist or other health care provider may be effective even though they have not been approved for patients under 18 years of age by the Food and Drug Administration (FDA) and are used "off-label". I understand that I need to ask the Patient's physician, dentist or other health care provider about any off-label use and other questions regarding the risk and safety of the Patient's proposed treatment.

No Guarantee: I acknowledge that no guarantees or warranties have been made as to treatment or services provided at Children's Health. I understand that all supplies, medical devices and other goods provided to the Patient are provided by Children's Health AS IS and Children's Health disclaims any expressed or implied warranties.

Patient Rights: If the Patient is receiving care at a Children's Health hospital / facility, I have received or been offered information regarding the Patient Rights and Responsibilities. This information tells me how to register a complaint or grievance that I might have relating to the Patient's care at the hospital / facility.

Communicable Disease Testing: I understand that, even with preventative measures, the Patient may be exposed to hospital acquired diseases and communicable diseases while receiving medical care and treatment. The Patient may be tested or screened for communicable diseases for the Patient's medical care or when necessary to prevent the spread of a communicable disease, including during a pandemic or epidemic, such as Coronavirus (e.q. COVID - 19). I agree that if a Children's Health employee, provider or other individual is exposed to the Patient's blood or other bodily fluid, pursuant to Texas law, Children's Health may test the Patient to determine the presence of communicable diseases including Human Immunodeficiency Virus (HIV) and hepatitis. I understand that the test results will be kept confidential and released only as authorized by law.

Specimen Disposal: I acknowledge that Children's Health may, in its sole discretion, remove, retain, or dispose of any tissue, fluids or body parts removed from the Patient.

Text / Voice / Automated Messaging: I authorize Children's Health to send communications by text message, voice and automated calls to the cell phone number I provide. I acknowledge that message and standard data rates and fees will apply, message frequency rates may vary, full security is not guaranteed over telephone networks, and I will need to protect my phone with a password or PIN to prevent unauthorized access. I understand that text and automated messaging may not be used by me to notify Children's Health of the Patient's health care needs. Children's Health Mobile Messaging privacy policy and SMS terms of service are available at https://www.childrens.com/footer/policies-procedures. Text HELP to 77444 for mobile messaging assistance, or text STOP to 77444 to opt out of Children's Health Mobile Messaging.

Advance Directive (ex. Directive to Physician regarding the withholding or withdrawing of life-sustaining treatment, Living Will, or Do Not Resuscitate Order): If the Patient is being admitted to a Children's Health hospital as an inpatient, I have received or been offered information regarding advance directives and Children's Health's policies related to them. I understand that it is my responsibility to provide a copy of the Patient's advance directive if such exists. For information regarding advance directives, I may request information from the Patient's attending physician, spiritual care, or social services.

The Patient ☐ DOES / ☐ DOES NOT have an executed advance directive.

Duration of Consent: I understand and agree this Consent for Care and Treatment is valid 1) for inpatient services, throughout the Patient's current hospitalization, and 2) for outpatient services, for the present visit and future outpatient visits at Children's Health for one year unless I revoke the consent prior to that time.

I have read and understand the information in this General Consent for Treatment and Acknowledgements form.

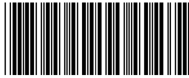
X (Parent/Legal guardian's signature IF patient is a minor) | X Required
Signature of Patient / Legally Authorized Representative | Date | Time

X (Parent/Legal guardian's name IF patient is a minor) | X Required
Printed Name of Patient / Legally Authorized Representative | Relationship to Patient

Signature of Witness / Interpreter | Date | Time

Printed Name of Witness / Interpreter ☐ Check if serving as interpreter & witness

*If telephone translation, name of Interpreter, ID number and Translation Services Vendor



CHILDREN'S HEALTH SYSTEM OF TEXAS

CONSENT
CMC1019-017NS Rev. 8/2022

General Consent for Treatment and Acknowledgements

Protected Health Information

Use and Disclosure of information: I understand that the Patient's medical and billing records are confidential and cannot be disclosed without valid written authorization except as authorized by law. Authorized disclosures are addressed in the Notice of Privacy Practices. I understand that medical information in the Patient's Children's Health medical and billing records includes past, present and future information and may include genetic testing / counseling, communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment / psychiatric / psychological care and alcohol / substance abuse diagnosis or treatment ("Medical Information"). For treatment, payment and healthcare operations purposes, I authorize release of Medical Information as part of the Patient's medical and billing records. I understand that Children's Health must keep the Patient's medical and billing records for a time period required by law and then may dispose of such records as permitted or required by law.

Electronic Sharing of Medical Information: I authorize Children's Health to disclose or use the Patient's Medical Information for treatment, payment and healthcare operations (collectively referred to as "Purposes"), or as otherwise allowed or required by law. I acknowledge Children's Health will release and send, electronically or otherwise, the Patient's Medical Information to third parties for the Purposes set forth above, or as otherwise allowed by law. I understand that Medical Information may no longer be protected by federal and state privacy laws once it is disclosed and may be subject to re-disclosure by the recipient. Medical Information may become part of the Patient's medical records kept at non-Children's Health healthcare providers and may be further disclosed.

Children's Health may participate in certain Health Information Exchange programs ("HIE(s)") to store and exchange the Patient's Medical Information. Certain Patient Medical Information from non-Children's Health healthcare providers may also be stored and shared in HIE(s), and Children's Health and these other providers can use HIE(s) to see the Patient's Medical Information for the Purposes set forth above, to coordinate the Patient's care, and as allowed or required by law.

Directory Information: The Patient's name may be included in Children's Health patient directory and Children's Health may acknowledge the Patient's name, room number and a general condition unless I object below.

This only applies to inpatient stays

☐ I do not want the Patient's information included in Children's Health's patient directory and request the Patient to be designated as a "confidential patient."

Special Guests: To enhance the patient experience, Children's Health hosts or sponsors certain activities at its facilities that include, without limitation, visits from sports teams, celebrities, local personalities and other individuals (collectively, "Special Guests"). I understand that certain Patient Medical Information may be shared with these Special Guests because of Patient's participation in Special Guest activities and authorize the sharing of Patient's Medical Information.

Notice of Privacy Practices: I acknowledge that I have received or been offered Children's Health Notice of Privacy Practices. Any questions or concerns may be directed to Children's Health Privacy Officer.

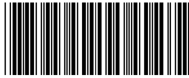
I have read and understand the information in this Protected Health Information form.

X (Parent/Legal guardian's signature IF patient is a minor) ______ X Required ______ ______
Signature of Patient / Legally Authorized Representative | Date | Time

X (Parent/Legal guardian's name IF patient is a minor) ______ X Required ______
Printed Name of Patient / Legally Authorized Representative | Relationship to Patient

______ ______ ______
Signature of Witness / Interpreter | Date | Time

______ ______
Printed Name of Witness / Interpreter ☐ Check if serving as interpreter & witness | *If telephone translation, name of Interpreter, ID number and Translation Services Vendor



CHILDREN'S HEALTH SYSTEM OF TEXAS

CONSENT
CMC1019-017NS **Rev. 8/2022**

General Consent for Treatment and Acknowledgements

Financial Responsibility and Assignments

Financial Responsibility: I agree to pay for the full billed charges for goods and services provided to the Patient regardless of insurance or benefit payments and understand that all amounts are due on request and are payable to Children's Health and providers who render services to the Patient at Children's Health ("Provider(s)"). Except as prohibited by law, I agree to pay for any charges not covered and covered charges not paid in full by insurance and / or a benefit plan including charges payable as co-insurance, deductibles, and non - covered benefits due to policy and / or plan limitations, exclusions, and / or failure to comply with insurance and / or plan requirements. An estimate of the anticipated charges is available upon request. I understand that estimates may vary significantly from the final charges because of a variety of factors such as the course of treatment, intensity of care, Provider practices, and the need to provide additional goods and services.

I also agree and understand that if the Patient's account becomes delinquent and is referred to an attorney or agency for collection or suit, I will be responsible for paying all charges, reasonable attorney fees, costs, and collection expenses. I consent to credit bureau inquiries and to receiving auto-dialed, computer generated and pre - recorded message calls to any telephone number provided during the Patient's registration process from Children's Health, Providers, and their affiliates and agents including, without limitation, any account management companies, independent contractors, or collection agents.

Medicare / Medicaid Patients Only: I understand that goods and services I request to be provided to the Patient may not be covered under Medicare or Medicaid as being reasonable and medically necessary for the Patient's care. I understand that Medicare / Medicaid determine the medical necessity of the goods and services requested for the Patient. If Medicare / Medicaid determine that certain goods and services are not medically necessary for the Patient's care and I request such goods and services be provided despite Medicare / Medicaid's denial, I understand I am solely responsible for payment for those goods and services. If the Patient is a Medicare / Medicaid managed care Patient, these provisions may not apply. I certify that the information given by or on behalf of the Patient in applying for payment under Medicare / Medicaid is correct. I authorize the release of medical or other information about the Patient to the Social Security Administration, intermediaries, or carriers as needed for Medicare / Medicaid claims.

Notice to Patients - Third Party Payor (Health Plan Member) Information: I acknowledge that based on the information I have provided about the Patient's third-party payor coverage, insurance, or benefit plan, Children's Health TCHATT services are provided at NO Cost

☐ IS / ☐ IS NOT a participating provider under the Patient's third-party payor coverage, insurance, or benefit plan.

Independent Providers: I understand Providers may bill and collect independently for their services. I further understand that a Provider may not be a participating provider with the same third-party payors as Children's Health; therefore, I may receive a bill for medical / dental / mental / behavioral health services from a Provider for the amount unpaid by the Patient's third-party payor coverage, insurance, or benefit plan. I understand I may request a list of Providers who have been granted medical / dental staff privileges to provide services at Children's Health. Also, I may request information from a Provider on whether Provider has a contract with the Patient's third-party payor coverage, insurance, or benefit plan and when I may be responsible for payment of any amounts not paid by the Patient's third-party payor coverage, insurance, or benefit plan. I understand that I will be responsible for paying Providers subject to the terms of the Patient's third-party payor coverage, insurance, or benefit plan.

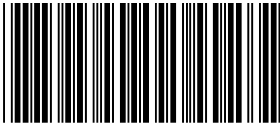
Assignment of Benefits: I irrevocably assign and convey directly to Children's Health, and any Provider, all benefits and all interest and rights, including any causes of action, ERISA (Employee Retirement Income Security Act) breach claim or other legal / administrative claim and the right to enforce payment, under any insurance policies, benefit plans, indemnity plans, prepaid health plans, third-party liability policies, or from another payor providing benefits on the Patient's behalf for goods and services provided to the Patient by Children's Health and Providers. I also authorize direct payment to Children's Health and Providers for the goods and services Children's Health and Providers provide to the Patient.

I authorize the Patient's plan administrator, insurer, and / or attorney to release to Children's Health and Providers all plan documents, summary benefit description, insurance policy, and settlement information upon written request from Children's Health or Providers needed to claim medical benefits.

Under this assignment, I convey to Children's Health and Providers all of my rights to claim or place a lien on benefits related to goods and services provided by Children's Health and Providers to the Patient, including rights to any settlement, insurance or applicable legal or administrative remedies, including damages arising from ERISA breach claims, and the right to appeal or pursue any denied or delayed claims. Children's Health and Providers have the right to: (1) obtain all information regarding the claim; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; and / or (5) participate in any administrative and judicial actions and pursue claims, a cause of action, or right against any liable party, insurance company, benefit plan, or plan administrator. Children's Health and Providers may bring suit against any such benefit plan, plan administrator or insurance company in my name and / or the Patient's name with derivative standing. This assignment is not and shall not be construed as an obligation of Children's Health and / or Providers to pursue such interest and rights.

I certify that I have read and understand the information in this Financial Responsibility and Assignments form.

X (Parent/Legal guardian's signature IF patient is a minor)	X Required	
Signature of Patient / Legally Authorized Representative	Date	Time
X (Parent/Legal guardian's name IF patient is a minor)	X Required	
Printed Name of Patient / Legally Authorized Representative	Relationship to Patient	
Signature of Witness / Interpreter	Date	Time
Printed Name of Witness / Interpreter ☐ Check if serving as interpreter & witness	*If telephone translation, name of Interpreter, ID number and Translation Services Vendor	



CONSENT

CMC67423-004NS Rev. 10/2022

CHILDREN'S HEALTH

Consent for Therapy, Counseling and Psychological Services

Place a patient label on all sheets

Location: ____________________

Patient Name: ____________________ Required

DOB: ____________________ Required

Medical Record Number: ____________________

CSN: ____________________

I understand that by signing this form that I am agreeing for the Patient, ____________________ (Patient's name) to receive psychology services, including services provided by Licensed Psychologists, Licensed Professional Counselors, Licensed Clinical Social Workers, or a Licensed Marriage and Family Therapist at Children's Health System of Texas hospital, facility, entity or program ("Children's Health")" which may include the following:

- Individual Therapy, Family Therapy, Group Therapy, or Play Therapy
- Psychological Testing, Assessment, or Evaluation and Report Writing

Procedures / Techniques

I understand that assessment and treatment activities may include a combination of the following: evaluation of intelligence and cognitive functioning; evaluation of emotional, social, and behavioral functioning; individual, family, or group therapy; health and behavior assessment and intervention. I understand that the Patient may be seen for multiple visits at Children's Health for these activities. The provider working with the Patient will keep me informed regarding changes to services being provided.

Duration

I understand that the duration of services will vary depending on the Patient's needs. The provider will be able to provide information regarding the anticipated duration of services.

Authority to Consent

By signing this form, I am representing there are no court orders in effect that would prohibit me from consenting to the mental health treatment and assessment of the Patient, If I have a Joint Managing Conservatorship of Patient, I represent that, if required, I have conferred with my child's other parent/joint conservator before proceeding with treatment.

Custody Matter Limitations:

Our providers support a cooperative parenting approach in working with divorcing, divorced or conflicted parents. The provider will not complete evaluations for the purpose of determining fitness for parental custody nor will the provider make recommendations regarding custody. It is agreed by signing this consent that the Patient and the Patient's legal guardians will not call or subpoena any provider to testify in a custody dispute.

Confidentiality

I understand that the information shared with the provider is confidential. I understand that I will be provided information about the Patient's treatment, and about findings and recommendations from screenings and assessments. If my child is receiving individual therapy services, the provider working with the Patient may share recommendations with the Legally Authorized Representative but may keep other information confidential between the provider and the Patient.

I understand and the Patient understands that the provider may not and at times by law cannot keep information confidential if it involves the following: the Patient is in imminent danger of harming themselves or others; discloses abuse or neglect of themselves or another minor, elderly person, or disabled person; is engaging in behavior that directly impacts their personal safety; or unless otherwise required by law.

I understand that Patient's medical record, including therapy records, may be shared with other providers for treatment purposes. In accordance with HIPAA, however, Patient's medical record will not be released to other third parties without written authorization or unless otherwise required or authorized by law.

Licensing Board

I understand each provider is licensed by the appropriate Texas state licensing board, and that I can receive information regarding the provider's licensing board and contact information for that board upon request.

Trainee involvement

I understand that my child may be seeing a licensed mental health professional and/or a psychology trainee for these services. Psychology trainees function under the supervision of a licensed mental health professional. Trainees will inform me that they are in training and will provide the name of the licensed professional supervising their work.

Consent Revocation

I understand that I can revoke my consent at any time. This consent will be renewed every 12 months.
I have read, understood, and agree to the terms and conditions contained in this form and have been given an opportunity to address any questions or request clarification for anything that is unclear to me.

X (Parent/Legal guardian's signature IF patient is a minor) X Required
Signature of Patient / Legally Authorized Representative | Date | Time

X (Parent/Legal guardian's name IF patient is a minor) X Required
Printed Name of Patient / Legally Authorized Representative | Relationship to Patient

Signature of Witness / Interpreter | Date | Time

Printed Name of Witness / Interpreter ☐ Check if serving as interpreter & witness | *If telephone translation, name of Interpreter, ID number and Translation Services vendor

White copy: Place in Medical Record Yellow copy: Patient Copy