POLK ADOLESCENT DAY TREATMENT

Serving children and their families since 1980

Intake Packet

Presented on _____

Dear Parents,

Enclosed is a list of materials your child will need to start the school year at PADTC. It is important that your child have these materials the first day of school so he/she can begin prepared and organized. We appreciate your help in joining with us to teach your child the necessary skills of preparation and organization. The first week of school is especially important for setting the tone of how the school year begins. Being prepared with materials is an excellent first step. Again, thank you for working with your child on this important first step.

The following materials are required:

1. **Three-ring binder, loose leaf notebook**
2. **Notebook paper**
3. **Pencils**
4. **Pens**
5. **Erasers**

Please feel free to discuss your child and his/her progress at any time throughout the year. We are looking forward to a busy and exciting year at PADTC and hope to have many chances to work with you on helping to ensure academic success for your child.

Kim Anderson
Learning Specialist, PADTC

Jackson Darling
Learning Specialist, PADTC

30 - 45 Day Evaluation

When a student and their family first enters the Polk Adolescent Day Treatment Center (PADTC) the initial 30 – 45 days is considered an evaluation period. This period offers both the family and PADTC staff an opportunity to evaluate whether or not the program really is a good fit to meet the needs of the student.

The type of questions that typically will be addressed may include:

- Are the structure and the expectations at PADTC a helpful fit?
- Is the student receiving adequate support to meet their needs?
- Does the student feel safe?
- Is the student able to be at PADTC in a safe manner?
- Is the student able to attend PADTC on a regular basis in order to take advantage of what the program has to offer?
- Is the family making it to family meetings on a regular basis?
- Is the family participating openly during family therapy?

As a team we will review these types of questions on a quarterly (every 3 months) basis to determine if PADTC continues to be the best choice to meet the need of the student and the family.

Rights and Responsibilities

It is the policy of PADTC to provide equal opportunity to access treatment services without regard to race, color, creed, national origin, age, sex or disability. We recognize the personal dignity of each individual in the provision of treatment and care. Further, each individual's treatment will be provided in the least restrictive environment possible.

Each individual served will have the right to a written individualized treatment plan, and the right to attend the Center in a safe environment. As PADTC is a family focused treatment center, we expect family/parental participation in the planning for treatment and the treatment process.

(I) (We) have been given an opportunity to discuss and have received a copy of (my) (our) Rights and Responsibilities.

Signature: _____ Date: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Consent for Psychological Treatment

(I) (We), the undersigned, parents (s) of _____ A minor, do hereby authorize Polk Adolescent Day Treatment Center, Inc. to provide psychological counseling and treatment to our child. Such treatment may include evaluation by or consultation with a psychiatrist, psychologist or other mental health or educational professional.

Signature: _____ Date: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Notice of Privacy Practices

Patient Acknowledgement and Receipt of
Pursuant to HIPAA and Consent for Use of Health Information

As you may be aware, certain health care providers are required to comply with new federal regulations that are intended to protect the privacy of patients' health information. The new regulations are in addition to state law which protects the privacy of your health information and, in fact, in some instances is stricter than the federal requirements. We have adopted Privacy Policies and Procedures for the office. The attached document, The Notice of Privacy Policies ("Notice") summarizes the office policies and procedures and describes how medical records or other important papers may be handled.

In order for us to treat you, we need you to provide us with a general written consent giving us your permission to share your health information with other healthcare providers, such as specialists who are involved in treating you, and with your health insurance company and other business associates of the practice. Generally, in order for us to disclose your health information for other purposes we will ask you for a separate written authorization.

Please review the Notice and sign the Acknowledgement and Consent form.

As has always been our practice, our policies and procedures are designed to show respect for patient privacy. If you have any questions about the Notice or the practices of our staff, please feel free to contact us.

Name_____ Date_____
Client Name

NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

AS YOU KNOW, THE FEDERAL GOVERNMENT HAS ENACTED PATIENT PRIVACY LEGISLATION KNOWN AS HIPAA (HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT). IT CHANGES THE WAY PATIENTS AND PATIENT RECORDS ARE HANDLED AND TRANSMITTED BY INSURANCE COMPANIES, HOSPITALS, PHYSICIANS, DENTISTS AND ALL OTHER HEALTH CARE PROVIDERS.

FORTUNATELY HIPAA WILL HAVE MINIMAL IMPACT IN THE DELIVERY OF SERVICES IN THAT ALL OF OUR STAFF UNDERGOES SPECIALIZED TRAINING TO MAINTAIN OUR PATIENT PRIVACY.

IN ORDER FOR US TO CONTINUE TO TREAT YOU, WE NEED YOU TO PROVIDE US WITH WRITTEN CONSENT GIVING US YOUR PERMISSION TO SHARE YOUR HEALTH INFORMATION WITH OTHER HEALTHCARE PROVIDERS, WITH YOUR HEALTH INSURANCE COMPANY AND OTHER BUSINESS ASSOCIATES OF THE PRACTICE.

PLEASE REVIEW THIS NOTICE AND SIGN THE ACKNOWLEDGEMENT AND CONSENT REVIEW FORM AND RETURN IT TO THE RECEPTIONIST. WE APPRECIATE YOUR BUSINESS AND, AS HAS ALWAYS BEEN OUR PRACTICE, OUR PROCEDURES ARE DESIGNED TO SHOW RESPECT FOR YOUR PRIVACY.

Acknowledgment of receipt of Notice of Privacy Practices and consent to use and disclosure for treatment, payment and operations purposes

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office. In addition, by signing below, I hereby consent to the use and disclosure of my healthcare information for treatment purposes, payment activities and healthcare operations of the office

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

Confidentiality in Regard to Human Sexuality

Human sexuality, from time to time, constitutes a part of the Center's group therapy program. The material presented includes information about birth control and where to obtain it and over current issues: e.g., Aids, sexually transmitted diseases. Parents are informed in advance that this material will be presented to their son/daughter.

In the course of individual therapy, sexuality, birth control, abortion and pregnancy may be discussed. These areas are the subject of therapy when deemed clinically relevant in the judgment of the therapist in consultation with the treatment staff. The therapist's goal is always to work toward communication between adolescent and parent about these issues. Determinations concerning confidentiality will regard the health and safety of the adolescent as primary.

As parents of _____

I have read the above information.

Signature: _____ Date: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Client Rights

Polk Adolescent Day Treatment Center (PADTC) will protect the human, civil, constitutional and statutory rights of adolescents and their families who are enrolled in the program. PADTC will make available at admission, in writing and through discussion with you, your rights as a client. These are to include:

1. Your right to provide consent for treatment.

2. Your right to decline to involve your child in treatment including a right to a second opinion at your own cost.

3. Your right to the confidential treatment of information.

4. Your right to review clinical records and consent to disclosure of clinical records.

5. Your right to receive treatment and educational services for your child in the least restrictive environment.

6. Your right to be treated with dignity and respect at all times.

7. Your right to participate in the development of the treatment plan and review of progress and changes.

8. Your right to information about the various treatment components of the program and the names of those individuals providing treatment.

9. Your right to know about the possible risks and benefits of any treatment.

10. Your right to make informed consent to fees for services.

11. Your right to file a grievance as provided under PADTC's grievance policy.

Release of Information

I hereby give my expressed written permission to:

_____to release

Name of Provider

Information concerning _____

Name of Adolescent

To _____

The purpose or need for this disclosure is:

_____

_____

_____

I further understand that this consent is subject to revocation at anytime except to the extent that action has been taken in reliance thereon.

_____ Date: _____

Signature of party authorized to release information

_____ Date: _____

Witness

This consent expires on : _____

Permission to Transport

I, the parent (guardian of) _____, hereby give my permission to PADTC staff to transport _____
To-from school and to-from recreational activities.

Signature _____ _____
Parent or Guardian Date

Signature _____ _____
Witness Date

Safe-Hold Agreement

Child's Name: _____

Date of Birth: _____ Entry Date: _____

Acts of endangerment toward self, others or property, or severe disruption of the milieu will result in safe-holding, time away from the group or suspension from the program, as appropriate.

_____
Clinical Supervisor

_____
Adolescent/Family Therapist
Polk Adolescent Day Treatment Center, Inc.

_____ _____
Parent/Guardian Date

_____ _____
Parent/Guardian Date

Consent to Emergency Treatment of a Minor

(I) (We), the undersigned, parent (s) of _____,
(Please Print or Type)
a minor, do hereby authorize and consent to any emergency x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and it is to be rendered under the general or special supervision of any physician and surgeon licensed by the State Board of Medical Examiners or the State Board of Dental Examiners of the State of Oregon, whether such diagnosis or treatment is rendered at the office of said physician or at any hospital licensed by the Health Division of the Department of Human Resources, State of Oregon.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, emergency, or hospital care being required which the aforementioned physician in the exercise of his best judgment and may deem advisable. This authorization is given in pursuant to the provisions of ORS 109.610 and ORS 109.660.

FINANCIAL AGREEMENT: The undersigned parent (s) or legal guardian agrees, that in consideration of the services to be rendered to this minor, we hereby individually obligate ourselves to pay, either through insurance or personally, the account of the hospital and doctors in accordance with their regular rates and terms. Should the account be referred for collection, we shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

This authorization shall remain effective until _____, 20____, unless sooner revoked.

Allergies or other comments: _____

_____

_____ _____
Family Doctor Dated

_____ _____
Address Signature of Parent/Legal Guardian

_____ (____)_____ (_____)_____
City Zip Phone Home Phone

_____ (_____)_____ (____)_____
Name of Minor Date of Birth Bus. Phone Cell Telephone

_____ _____
Additional Emergency Contact / Relationship Signature of Parent/Legal Guardian

_____ (_____)_____
Address Home Phone

(_____)_____ (_____)_____ (____)_____
Phone Bus. Phone Cell Telephone

_____ _____
Signature of Witness Insurance Company Policy #

Emergency Medical Plan

STUDENT'S NAME: _____

1) Medical Condition or disability:

_____

_____

2) Current Medical Treatment: ❑ Yes ❑ No

Medication: ❑ Yes ❑ No

Physician: _____

Prescription:

Name: _____ Dosage:_____

Name: _____ Dosage:_____

Name: _____ Dosage:_____

3) Past emergencies involving this condition:

_____

4) Course of Treatment:

_____

5) Step-by-step plan of action in case of emergency:

_____

_____

Parent Signature _____ Date: _____

Van/Transportation Rules

Riding the PADTC van is considered both a service and a privilege. While riding the van the student is involved in a merit and demerit system.

Each time a student breaks a rule he/she receives a demerit. Following is an explanation of the system and the rules.

THE RULES ARE:

1. **Keep your language clean & respectful (No abusive language – name calling, cussing, sexual jokes)**

2. **Respect other's physical space (Keep your hands & feet out of other's space; no hitting)**

3. **Talk in a normal social voice (No excessive noise – yelling)**

4. **No eating**

5. **Take care of your own belongings (No littering of van – trash, throwing things)**

6. **Respect other's property (No improper care of van – walking on seats, feet on windows, roof, etc., slamming doors; leave other's things alone)**

7. **Be a decent respectful person sensitive to the rights and needs of others**

If the student receives three (3) demerits during a two week period of time they will be taken off the van for three to five days or given specific jobs at the Center.

If a student receives "0" demerits during the week he/she receives $5 play money to be used to purchase items at a mini-auction.

Family and student support of these expectations is important because daily PADTC attendance is expected even when student has forfeited the privilege of riding the PADTC van.

Please discuss these Rules and Regulations with your adolescent.

School Closure Guidlines

Polk Adolescent Day Treatment Center will follow the Dallas School District's decision regarding emergency closure of school opening delays. Decisions will be made by 6:00 a.m. and announced over one of the attached list of radio and television stations.

One of the following decisions will be announced:

1. School closure (classes will not be held and buses will not run).
2. One-hour delay (morning bus will be delayed one hour as well as the start of school).
3. Two hour delay (morning bus will be delayed two hours, as well as the star of school).

If Dallas Schools are closed, PADTC will be closed. If Dallas Schools are on a delayed schedule, PADTC transportation will also be on the announced delayed schedule.

On rare occasions it may occur that PADTC will be closed but the Dallas School District will be open or announce a delay. In those instances you will be contacted directly by PADTC.

As students at PADTC come from a variety of school districts and transportation arrangements, you will be notified of special arrangements if they apply to you. Unless so notified, the guidelines listed above will be followed.

Every attempt will be made to contact you in addition to the public announcement. However, conditions may not always allow this to happen. The radio/TV announcement will give you the necessary information.

Please contact us if you have any questions.