Gaggle Therapy Services Client Consent Form

Gaggle Therapy Services
Informed Consent Form

Client Name: _____
Client Date of Birth: _____ (MM/DD/YYYY)

Your permission is required to have your child participate in teletherapy sessions with Gaggle Therapy. The district shall determine the format, which may be individual, group, or family-based.

Because counseling is based on a trusting relationship between a mental health provider and client, the provider will keep information shared by the child confidential except in certain situations in which an ethical responsibility limits confidentiality. You will be notified under the following circumstances:

1. The student reveals information about hurting himself/herself or another person.
2. The student or another person may be in physical danger.

Additionally, it may be pertinent to share some of your child's personal information (such as session dates and attendance) with the school district for invoicing, identifying support, and record keeping purposes. In cases pertaining to invoicing, your child's name will be removed. By signing this release, you are consenting to allow Gaggle Therapy to share some information with your child's school or district.

In the event the client is transferred from one mental health provider to another at Gaggle, informational continuity of care will be performed. In an effort to provide little to no disruption in care/services, the incoming mental health provider may request to speak to the previous provider and/or read the previous provider's notes.

In our commitment to delivering personalized care, students may be connected with an appropriate provider, such as therapists, therapist associates (under supervision), or coaches. Therapist associates are supervised by an independently licensed clinician, ensuring the delivery of the highest quality service.

RISKS:
I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

DEFINITION OF TELEMENTAL HEALTH SERVICES:
Telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

By typing my name below, I give my informed consent for my child to participate in counseling. I understand that anything that my child shares will be kept confidential except in the above-mentioned cases.
Consent for Services: Required

- ☐ Yes
- ☐ No

Client/Guardian Signature: _____
Date: _____ (MM/DD/YYYY)

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Additional Consent Form

Now that you have agreed to participate in services, you have the option to share information between Gaggle and school district personnel. Information shared may include:

- Current stressors
- Evidence-based strategies for client to utilize
- How school staff can support client

I have reviewed and understand Gaggle's Additional Consent Form: Required
☐ I **give** my permission for Gaggle to release information to relevant school district staff, as appropriate to the client's needs.
☐ I do **not** give permission to release information to relevant school district personnel.
☐ I am a **district staff** member and do not give permission to release information to relevant school district personnel.

Date: _____ (MM/DD/YYYY)
Client/Guardian Signature _____

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Privacy and Confidentiality Agreement

Your privacy and confidentiality are extremely important to us. This document explains how your Protected Health Information (PHI) will be handled in compliance with federal and state laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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1. Use and Disclosure of Protected Health Information (PHI)
By signing this agreement, you understand and agree that:

- Gaggle may use and disclose your PHI for purposes of providing treatment, obtaining payment for services, and conducting healthcare operations.
- Examples of permitted disclosures include:
- Sharing information with your insurance provider to obtain authorization or process claims for payment.
- Communicating with other healthcare providers involved in your care.

2. Confidentiality of Telehealth Services
For telehealth services, you acknowledge the following:

- Communication via telehealth may involve the transmission of personal medical information over electronic platforms.
- Gaggle takes all reasonable precautions to protect your data, including using encrypted software platforms.

3. Rights Regarding Your Information
You have the right to:

- Access and request copies of your medical records.
- Request limitations on certain uses and disclosures of your PHI (subject to provider agreement).
- Withdraw consent for sharing your information, except where disclosure is required by law.

4. Limits of Confidentiality
There are situations where Gaggle is legally required to disclose your information without your consent, including:

- If there is a threat to your safety or the safety of others.
- Suspected abuse or neglect of a child, elder, or vulnerable adult.
- Legal requirements such as court orders or subpoenas.

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Privacy and Confidentiality Agreement

Acknowledgment and Consent

By Acknowledging this form, you acknowledge that you have read and understood the terms outlined in this **Privacy and Confidentiality Agreement**. You consent to the use and disclosure of your PHI as described herein. You understand your rights and responsibilities under HIPAA and state regulations.

Date: _____ (MM/DD/YYYY)

Client/Guardian Signature _____

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Patient Rights

We are committed to ensuring you receive quality care with respect and understanding. This document outlines your rights as a patient. Please read it carefully. If you have any questions or need further clarification, please ask your provider.

1. Your Rights to Respect, Dignity, and Non-Discrimination
   - You have a right to be treated with courtesy, dignity, respect and carefree of discrimination regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.
   - (Governing Law: CMS Conditions of Participation, ADA, Civil Rights Act - Title VI)

2. Your Rights to Be Free from Abuse and Restraint
   - You have the right to receive care in a safe setting, free from all forms of abuse, neglect, or unnecessary restraint.
   - (Governing Law: CMS Conditions of Participation)

3. Your Rights to Participate in Decisions About Your Care
   - You have the right to know your treatment options, make decisions about your care, and refuse treatment if you choose.
   - When a patient or an individual is unable to make decisions about their care, treatment, or services delivered via telehealth, the organization involves a surrogate decision-maker (School District, School Counselor, Family, etc.) in accordance with law and regulation.
   - The organization involves the patient's or individual's family in care, treatment, or services decisions to the extent permitted by the patient, individual served, or surrogate decision-maker, in accordance with law and regulation.
   - The organization accommodates the right of the individual served to request the opinion of a consultant.
   - The organization accommodates the right of the individual served to request an internal review of their plan for care, treatment, or services.
   - (Governing Law: Patient Self-Determination Act, CMS Conditions of Participation)

4. Your Rights to Receive Information in a Manner They Understand
   - The organization provides information in a manner tailored to the age, language, and ability to understand the patient or individual served.
   - If you have limited English proficiency, you are entitled to receive interpreter services at no cost.
   - The organization provides information to the patient or individual served who has vision, speech, hearing, or cognitive impairments in a manner that meets their needs.
   - (Governing Law: Civil Rights Act - Title VI)

5. Your Rights to File Complaints or Grievances
   - You may voice concerns about your care without fear of retaliation. Providers have a process for addressing complaints and responding in a timely manner.
   - Patient or Surrogate decision-maker may file a complaint by:
   - Verbal or Written Complaint submitted to: Referring School Counselor
   - Relevant State Authority

- Office of Inspector General

(Governing Law: CMS Conditions of Participation, HIPAA)

6. Your rights to Progress Notes

- I understand that I may request access to my child's therapy progress notes, which may include general information such as session goals, attendance, and observable progress.
- Limits on Access: I understand that some therapy notes—such as private therapist notes used only for clinical purposes—are not shared.
- I also understand that access to notes may be limited if:

1. Sharing the information could harm my child.
2. My child is legally able to consent to their own treatment.
3. Legal or custody arrangements restrict access.

- How to Request Notes: I agree to submit any requests for therapy progress notes in writing using the designated Release of Information (ROI) form.
- Therapist Communication; I understand that therapists may provide summary updates as an alternative to sharing full progress notes, to support collaboration while maintaining trust in the therapeutic relationship.

7. Additional Rights for Individuals in Foster Care

- To participate in the development of their case plan, as appropriate to their age and maturity
- To access routine, preventive, and emergency medical, vision, behavioral health, dental, and rehabilitation care
- To maintain contact with their ethnocultural heritage
- To participate in recreational skill-building and social opportunities
- To be protected from harassment and abuse
- To be supported in developing and expressing their spirituality
- If information regarding the family of origin is shared with Gaggle and/or the provider, the family of origin may be invited to:
- Participate in the case plan of the individual in foster care, unless otherwise indicated in the case plan
- Maintain contact with the individual in foster care, unless otherwise indicated in the case plan
- Access services that address the conditions that led to foster placement
- If information regarding the foster family is shared with Gaggle and/or the provider, the family may be informed of:
- Crisis situation(s) and/or emergency supports needed
- Strategies to support the individual in foster care
- Identified needs of the individual in foster care

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Patient Rights

Acknowledgment of Agreement

By Acknowledging this form, you acknowledge that you have read and understood your Patient Rights. You agree to its terms and understand your rights and responsibilities.

Date: _____ (MM/DD/YYYY)
Client/Guardian Signature _____

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Gaggle Therapy Services
Cancellation/No-Show

Clients are expected to attend and participate in their sessions. If unable to attend the session, please reach out to your therapist to reschedule at least 24 hours in advance. Sessions canceled or not attended with less than 24 hour notice are considered "no-show" sessions. Clients with excessive cancellations/"no-shows" may be considered for discharge (removed from services).

Attendance Policy:

1. After the second and third "no-show" sessions, the Gaggle therapist will review the client's engagement in services and district requests to determine if the client should be discharged. *Please note, some school districts require clients to be discharged after the second or third "no-show". Your therapist will discuss these expectations with you further.
2. If permitted to continue and the client has a fourth "no-show" session, this will result in discharge from services.

I confirm that I have reviewed Gaggle's no-show policy: Required
☐ Yes
☐ No

1. Is the client currently receiving therapy services outside of the school setting? *Please note, this DOES NOT include school counseling*: Required
☐ *Yes
☐ No

*** We are unable to support this client if they are receiving therapy elsewhere. Please contact *staff@gaggletherapy.com* if you have any questions.**

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1. **Client Address: Required**
Street: _____ City: _____ State: _____ Zip Code: _____ Phone Number: _____

2. **Preferred Method of Contact: Required**
☐ Phone
☐ Email
☐ Text
☐ No Preference

3. **Primary Emergency Contact: Required**
☐ Name:
☐ Phone Number:
☐ Email:
☐ Relationship to Client:

4. **Secondary Emergency Contact: Optional**
☐ Name:
☐ Phone Number:
☐ Email:
☐ Relationship to Client:

5. **Gender Identity (must check one): Required**	
☐ Male	☐ Non-Binary
☐ Female	☐ Other: _____

6. **Preferred Pronouns (must check one): Required**	
☐ He/Him	☐ They/Them
☐ She/Her	☐ Other: _____

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7. Describe any medical or mental health diagnoses (e.g., ADHD, asthma) and current treatments (e.g., psychiatry, behavior therapy): Required

8. Describe any recent (past 6 months) mental health/psychiatric supports, including: outpatient treatment, psychiatric hospitalization, psychiatric medications, suicidality, harm of self or others, current or recent legal charges, etc.: Required

9. List Any Current Medications. Please Include: Name, Prescriber, Dose, Method (how it is taken), Frequency, Purpose Required

10. Date of most recent physical examination. (If it has been more than one year since your last physical exam, please reach out to your primary physician to schedule an appointment or school district for additional resources.) Required

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11. List special client concerns/situations for the therapist to be aware of (e.g., attendance, homelessness, divorce/custody, legal issues, financial challenges, 504 plan, IEP, etc). Required

12. Is this client being referred to satisfy legal or school requirements? For example: Custody, guardianship, school suspension or any legal related concerns. Required

13. Provider Preference (must check one): Required
☐ Male
☐ Female
☐ No Preference

14. Primary Language: Required

15. Can sessions be held in English? Required
☐ Yes
☐ No

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16. Session Time Frame Preference (must check atleast two): Required
☐ In School
☐ Day Time - Weekend
☐ Evening – Weekday
☐ Evening - Weekend

17. Who should receive text reminder? Required
☐ Emergency Contact
☐ Client/Responsible Party
☐ Opt out of text messages

18. Who should receive SESSION EMAILS, in addition to the Client Account Email? Optional
☐ Emergency Contact
☐ Referring Staff Member