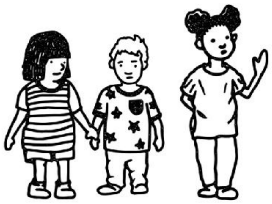
KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

INITIAL TREATMENT AGREEMENT

1. Each clinic-based therapy session is approximately 45 - 60 minutes in duration. Each home, telehealth or school-based visit is 60 minutes in duration. For ABA services, each client will have a unique schedule dependent on the results of the initial assessment. The BCBA will indicate recommended hours for each client on the initial assessment report.
2. Information given to the clinician is confidential and can only be released with your specific written consent, unless you are referred for services under legal circumstances, if emergency conditions prevail, or an unusual situation occurs involving the judicial system. Kinder Konsulting and Parents Too contractors are required by law to report all suspicions of neglect or abuse to the appropriate agency, as well as threat to harm or intent to harm self or someone else.
3. Any information pertaining to your mental health should be discussed with your therapist. It is your responsibility to provide your/your child's social security number and date of birth in order to confirm appointments or identify your/your child's therapist or psychiatrist. No other information will be provided overt the phone unless Kinder Konsulting and Parents Too staff can confirm your identity.
4. An individualized treatment plan will be completed with the individual receiving services, parent/legal guardian, and the clinician. All involved will voluntarily agree to follow the plan as outlined.
5. Efforts will be made to arrange appointments, which will be as convenient as possible for you to attend. At times, compromises will be necessary.
6. If you know you cannot keep a scheduled appointment, please call to cancel at least 24 hours in advance.
7. If you cancel or do not show up for two scheduled appointments, a supervisor may review your case. It may be determined that you are no longer eligible to receive services. You will be informed of any plans to terminate services.
8. Kinder Konsulting and Parents Too clinicians are not on call and are unable to address issues outside of normal business hours (8:30 - 5:00). If a crisis situation occurs, you are advised to proceed to the nearest emergency room.
9. Children should not be dropped off for their appointments or left unattended while in the waiting room.



KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

ROLE OF THE CLINICIAN

1. The ongoing provider will provide you with a program description and information about their own experience and credentials.
2. The ongoing provider will work with you to assess problem areas and establish goals for treatment specific to your individual set of needs. The ongoing provider will develop the treatment plan and approach with you during the assessment process.
3. Discharge planning begins at the time of admission and continues throughout the treatment process.

I acknowledge that I have received a copy of this treatment agreement and a brochure listing my rights as a client.

☑ By checking here, and giving my email address and cell phone number below, I am consenting to electronic Communication, including emails and SMS messages.

Signature of Client and Parent/Guardian: _____

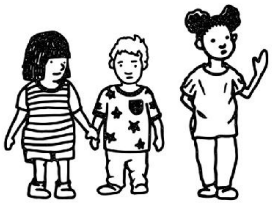
Name of Parent/Legal Guardian: _____ **Date:** _____

Parent/Guardian Email: _____ **Cell:** _____

Signature of Clinician: _____

Name of Clinician: _____ **Date:** _____

Clinician Cell: _____



KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

INTAKE CONSENTS

STATEMENT OF AUTHORITY TO CONSENT

I certify that I have the legal authority to consent to treatment, medication, release of information, and all legal issues involving the above-named client. Upon request, I will provide Kinder Konsulting & Parents Too, Inc. with proper legal documentation to support this claim. I further agree that if my status as legal guardian should change, I will immediately notify Kinder Konsulting & Parents Too, Inc. of the name, address, and telephone number of the person who has assumed guardianship of the above-named client.

CONSENT FOR TREATMENT AND TREATMENT LOCATION
I consent for the above-named client to participate in:

☐ **Mental health out-patient assessment and services** ☐ **ABA assessment and services**
through Kinder Konsulting & Parents Too, Inc. at the following locations:

☐ Yes ☐ No **Client Home**: _____

☐ Yes ☐ No **Client School**: _____

☐ Yes ☐ No **Other**: _____

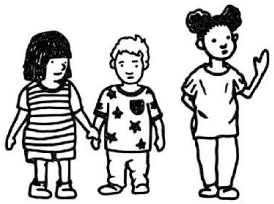
I also consent for the following individuals/organizations to be involved in the treatment of the above-named client. I understand that these persons will need to have access to protected health information for the purpose of assessment, treatment, and health care operations.

School Personnel: ☐ Teacher ☐ Counselor ☐ Behavior Specialist ☐ Principal
☐ SAFE Coordinator ☐ Other: _____

Other Family Members: ☐ Stepparent ☐ Siblings ☐ Grandparents
☐ Foster parents ☐ Other: _____

Referral Source Agency & Name: _____

Other Current Treatment Provider Names & Agencies: _____



KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

PRIVACY EXCEPTIONS

In some circumstances, we are required to report private information about you. We have a duty to report suspicion of child abuse and neglect to the State of Florida. We have a duty to warn potential victims if we believe that their lives are in danger. Other exceptions to privacy are explained in the Privacy Notice.

FUNDING AUTHORIZATION

I authorize Medicaid _____ (funding agency) to pay for services directly to Konsulting & Parents Too, Inc. I understand that I will be responsible for the charges that this funding source does not cover. I further understand that protected health information will need to be released to the above-named funding source in order to process claims and obtain reimbursement. If Medicaid does not pay, the agency may submit payment through Central Florida Cares Health System (CFCHS). I authorize CFCHS to pay for services directly to Kinder Konsulting & Parents Too, Inc., and I understand that in this process, protected health information will need to be released to CFCHS in order to process claims and obtain reimbursement.

GRIEVANCE PROCEDURE

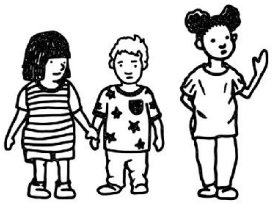
If you are not satisfied with the services, you receive from the staff assigned to you or wish to make a complaint please call the Program Manager. If you are not satisfied with the response from the Program Manager, you may submit a written grievance to the Program Director, who will respond to your grievance within 14 days. If you are not satisfied with the response of the Program Director, you may forward your written grievance to the Executive Director. The Executive Director will render a decision within 14 days, which will be final. A copy of the full grievance procedure is available upon request.

A copy of this release shall be valid as the original.
THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED, OR UPON DISCHARGE

☐ **I received a copy of the Kinder Konsulting & Parents Too, In "Notice of Privacy Practices."**

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.***

The information on this page has been explained to me. I understand that I may revoke consent for the above at any time, however, I cannot revoke consent for action that has already been taken.



KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

Signature of Client and Parent/Guardian: _____

Name of Parent/Legal Guardian: _____ **Date:** _____

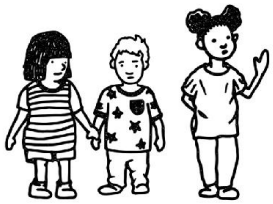
Parent/Guardian Email: _____ **Cell:** _____

Signature of Clinician: _____

Name of Clinician: _____ **Date:** _____

Clinician Email: _____

Clinician Cell: _____



KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices tells you how Kinder Konsulting & Parents Too, Inc. may use or disclose information about you. Not all situations will be described. KKP is required to give you notice of our privacy practices for the information we collect and keep about you.

I acknowledge receipt of Notice of Privacy Practices:

I have had a chance to ask questions about how my information will be used, disclosed, and protected.

Signature of Client and Parent/Guardian: _____

Name of Parent/Guardian: _____ **Date:** _____

Email of Parent/Guardian: _____ **Cell:** _____

Is this an Emergency Treatment Situation? ☐ Yes ☐ No

HOW NOTICE WAS PROVIDED

Was written Notice of Privacy Practices provided? ☐ Yes ☐ No
Was Notice given in another way? ☐ Yes ☐ No
If written Notice was not provided, method of Notice:
☐ Verbal ☐ Fax ☐ Email ☐ Website

ACKNOWLEDGEMENT OF RECEIPT

Has client signed Notice of Receipt of Privacy Practices? ☐ Yes ☐ No
If no, did client otherwise acknowledge Notice of Privacy Practices? ☐ Yes ☐ No
If Notice was acknowledged in another way, method of acknowledgement:
☐ Verbal ☐ Fax ☐ Email ☐ Website

If no acknowledgement was received, document why you were unable to get an acknowledgement from the client and the efforts you made to get the acknowledgement: _____

Signature of Person Recording Acknowledgement of Receipt of Privacy Practices:

_____

Name of Person Documenting: _____ **Date:** _____

KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

REPRESENTATION OF LEGAL AUTHORITY (Consent to Treat)

STATEMENT

By my signature below, and as an inducement to Kinder Konsulting and Parents Too, Inc. to provide services to my minor child described above, I hereby represent and consent as follows.

I have the legal right to authorize treatment for my minor child described above. ☐ Yes ☐ No

I hereby consent to treatment of my minor child described above. ☐ Yes ☐ No

I have the legal right and authority to access the medical/therapy records of my minor child above and no Court has limited my rights. ☐ Yes ☐ No

Signature of Client and Parent/Guardian: _____

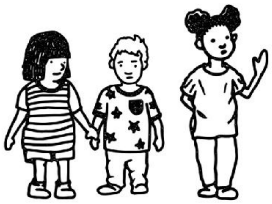
Name of Parent/Legal Guardian: _____ **Date:** _____

Parent/Guardian Email: _____ **Cell:** _____

Signature of Clinician: _____

Name of Clinician: _____ **Date:** _____

Clinician Cell: _____



KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

YOU HAVE THE RIGHT!

1. To be respected at all times.
2. To dignity, privacy, and humane care.
3. To be involved in your treatment.
4. To know what kind of medication you may be taking and to understand what the medication is for.
5. To receive prompt and appropriate medical care.
6. To have your clinical record kept confidential at this program.
7. To have information communicated to you and your family (verbally and written) in your native language.
8. To call the ABUSE HOTLINE at 1-800-962-2873 if you feel any staff person here has threatened you, hit you or asked you to do anything sexual; the Human Rights Advocacy Committee (1-800-342-0825) and/or the Advocacy Center for Persons with Disabilities (1-800-342-0823). You should always report anything that really bothers you to the Program Director or your child's ongoing provider.
9. To quick responses to questions.
10. To know who is treating you.
11. To know the rules and regulations of your program.
12. To report any complaint, you may have regarding these rights by using the grievance procedure.

Signature of Client and Parent/Guardian: _____
Name of Parent/Legal Guardian: _____ **Date:** _____
Parent/Guardian Email: _____ **Cell:** _____

Signature of Clinician: _____
Name of Clinician: _____ **Date:** _____
Clinician Cell: _____

KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

CONSENT AND WAIVER

CONSENT AND WAIVER

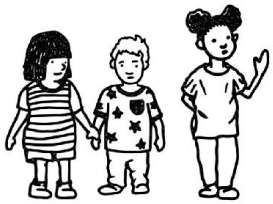
The undersigned acknowledges that Kinder Konsulting & Parents Too, Inc., hereinafter referred to as KKP, is providing services to, or for the benefit of requiring, as partial consideration for providing said service, the execution of this Consent and Waiver which is being executed by the undersigned as the natural parent, guardian, or other responsible party for the aforementioned patient/client.

The specific terms of this Consent and Waiver are as follows:

1. KKP is providing services including, but not necessarily limited to, mental health consultation, behavior analysis services, evaluation, program development, and treatment of the aforementioned patient/client.
2. KKP will provide the aforementioned services in a professional manner and will take every precaution within reason to ensure the safety of the patient/client. KKP has informed the undersigned that treatment strategies are often play-based or interactive in nature and accordingly, can potentially pose risk of injury to the patient/client.
3. The undersigned herby acknowledges the potential risk of inadvertent injury to the patient/client.
4. The undersigned hereby acknowledges the potential risks of injury based on the strategies implemented by KKP and consents to the same despite the disclosed risks. Furthermore, the undersigned herby waives, on behalf of the undersigned as well as the patient, together with the heirs, devisees, or assignees of the undersigned or the patient, any and all liability for personal injury, physical, or otherwise, which may be incurred by the patient/client as a result of the provision of services.
5. The undersigned, on behalf of the undersigned as well as the patient/client, the heirs, devisees, or assignees, hereby agrees to hold harmless and indemnify KKP from any and all losses which KKP may experience or be exposed to by reason of injury to the patient for provision of the services as outlined herein. The indemnification shall include any and all losses as well as attorney's fees and costs.
6. The undersigned acknowledges and agrees that the execution of this form, and the promises and conditions as set forth herein, are partial consideration for the provision of services to the patient/client by KKPT.
7. The undersigned acknowledges and agrees that the undersigned fully understands the terms of this Agreement and has had an opportunity to consult with independent counsel prior to executing this form.

Signature of Client and Parent/Guardian: _____
Name of Parent/Legal Guardian: _____ **Date:** _____
Parent/Guardian Email: _____ **Cell:** _____

Signature of Clinician: _____
Name of Clinician: _____ **Date:** _____
Clinician Cell: _____



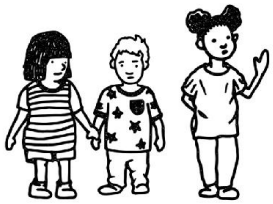
KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

CONSENT FOR IN-PERSON SERVICES AND WAIVER

I understand and acknowledge that allowing my child to have direct contact with their therapist for face-to-face sessions in my home may pose a health risk to my child, my family, and/or the therapist if there is any inadvertent exposure to viruses, including but not limited to COVID-19. To that end, I attest and agree to the following:

- I understand that the therapist and agency are informed of any applicable CDC guidelines and will take the appropriate measures to mitigate risks of illness.
- I agree that I, my child, and all others in the home will participate in measures recommended by the therapist to limit and prevent the transmission of illnesses. This may include wearing face coverings, having our temperature taken, and other measures.
- I understand that the therapist will not come to my home to conduct sessions in person if they have symptoms such as fever, sore throat, cough, or other flu-like symptoms.
- I agree to inform the therapist, prior to their visit, of symptoms my child or others in the home may present such as fever, sore throat, cough, or other flu-like symptoms. I understand that sessions will not be conducted in the home if symptoms are present.
- I understand that if the therapist, upon arriving at my home, believes that my child or others in the home may have symptoms, the session will be cancelled.
- I understand and agree that for the safety of all, both the therapist and I must openly communicate regarding concerns of possible contagion, such as my child, members of our household and/or the therapist having symptoms of, or being diagnosed with, a contagious illness.



KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

Notwithstanding all the above, I understand that despite best efforts by Kinder Konsulting ("the agency"), therapist, myself and my household, some illnesses may still be spread, including when all parties are asymptomatic.

I understand that by my child participating in in-person therapy sessions, I am assuming the risk of possible exposure to contagious illness for myself, my child, and my household. I understand that I have the option of my child receiving therapy through telehealth and I have chosen for my child to receive in-person therapy services. I will notify the agency if at any time I want my child to receive services through telehealth. I understand that the agency may require that services be provided through telehealth if the agency deems it necessary.

- I agree that neither the agency, therapist, nor myself and my household will be liable for illnesses contracted while in person therapy sessions occur with my child.

Signature of Client and Parent/Guardian: _____

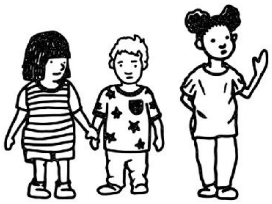
Name of Parent/Legal Guardian: _____ **Date:** _____

Parent/Guardian Email: _____ **Cell:** _____

Signature of Clinician: _____

Name of Clinician: _____ **Date:** _____

Clinician Cell: _____



KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

NO SHOW AND CANCELLATION POLICY

Regular attendance is required for our services to be effective. Irregular attendance also cost both the staff person and the program time and money. It is therefore the responsibility of the client or his/her legal guardian to attend all scheduled appointments.

NO SHOW POLICY

1. For in person services, if you do not call to cancel before the staff person has left to go to your house, it is considered a NO SHOW.
2. For each NO SHOW, you will be billed a NO SHOW fee of $20, to partially cover the costs involved. The bill will be sent to your house with a return envelope to be mailed back to Kinder Konsulting & Parents Too, Inc.
3. After the first NO SHOW, the staff person will call to reschedule the appointment.
4. After the second NO SHOW, the Director of the program will send you a letter explaining that you must call her if you desire to continue services.
5. After the third NO SHOW, your case will be closed.
6. For ABA services, please see additional policy consent regarding no show sessions, attendance, and schedule agreement.

KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

CANCELLATION POLICY

1. For in person services If you reach the staff person before he/she has left to come to your house, it is considered a CANCELLATION.
2. After the first cancellation, the staff person will call you to reschedule.
3. After two cancellations in a row, the Director of the program will send you a letter explaining that you must call him/her if you desire to continue services.
4. After the third cancellation in a row, your case will be closed.
5. If you cancel three times, with some attendance in between each cancellation, your therapist will discuss with you some possible solutions to the problem of irregular attendance.
6. For ABA services, please see additional policy consent regarding cancelled sessions, attendance, and scheduled agreement.

I the undersigned understand Kinder Konsulting & Parents Too, Inc. No Show & Cancellation Policies and agree to its' terms.

Signature of Client and Parent/Guardian: _____

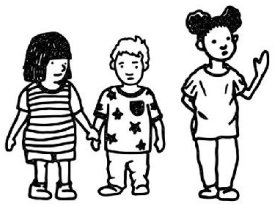
Name of Parent/Legal Guardian: _____ **Date:** _____

Parent/Guardian Email: _____ **Cell:** _____

Signature of Clinician: _____

Name of Clinician: _____ **Date:** _____

Clinician Cell: _____



KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

VIDEO TAPING WAIVER

The undersigned acknowledges that Kinder Konsulting & Parents Too, Inc., hereinafter referred to as KKP, is providing services to, or for the benefit of requiring, as partial consideration for providing said service, the execution of this Consent and Waiver which is being executed by the undersigned as the natural parent, guardian, or other responsible party for the aforementioned patient/client.

The specific terms of this Consent and Waiver are as follows:

1. I understand that when KKP is providing services to the aforementioned patient/client in a setting other than the KKP office, such as a school, daycare facility, or other location, it is possible that the owner/operator of such facility or location may be engaged in video and/or audio recording for security or other purposes.

2. If and to the extent that KKP has actual knowledge that any such recording is taking place, your child's ongoing provider will use his/her best efforts to inform the parent, guardian, or responsible party of the client.

Although KKP will use its best efforts to maintain as much discretion as is practical and to provide services to the client on a confidential basis, the undersigned consents to the rendering of services to the patient in locations where video and/or audio recording may be taking place and understands and acknowledges that KKP cannot assure the confidentiality and privacy of services rendered in such settings. Accordingly, the undersigned waives and releases any claim against KKP relating to the performance of services by KKP in non-confidential and non-private settings such as those described above where video and/or audio taping may be taking place.

Signature of Client and Parent/Guardian: _____

Name of Parent/Legal Guardian: _____ **Date:** _____

Parent/Guardian Email: _____ **Cell:** _____

Signature of Clinician: _____

Name of Clinician: _____ **Date:** _____

Clinician Cell: _____

KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

TELEHEALTH/TELEMEDICINE CONSENT

The undersigned acknowledges that Kinder Konsulting & Parents Too, Inc., hereinafter referred to as KKP is providing services to, or for the benefit of _____, and is requiring, as partial consideration for providing said service, the execution of this Consent and Waiver which is being executed by the undersigned as the natural parent, guardian, or other responsible party for the aforementioned patient/client.

The specific terms of this Consent and Waiver are as follows:

I, the undersigned, understand and agree to the following:

1. I understand that KKP utilizes a telehealth platform that is fully HIPAA compliant and adheres to the American Telemedicine Association (ATAP practical guidelines and standards, and as such, is appropriate for mental health services. This notwithstanding, I understand that when KKP is providing services to the aforementioned patient/client through telehealth there may be possible limitations/hazards due to the nature of telehealth therapy Bu using this service, I acknowledge and agree to hold the agency harmless from any loss or damages I may incur by the use of these services due to factors out of the agency control.

2. Although KKP will use its best efforts to maintain as much discretion as is practical and to provide services to the client on a confidential basis, and in a private setting, it is contingent on the ability of the client to receive telehealth services in a private setting. I agree to maintain the level of privacy and will not hold the agency responsible for someone listening to the client's conversation in my home setting. I also agree to notify the therapist of any person in the room who may not be visible to the camera. Accordingly, I waive and release and claim against KKP relating to the performance of services by KKP in setting such as those described above.

3. I agree to be responsible for setting up the video conferencing system at my site (at the direction of KKP therapist or staff) and establishing a private space for services to take place. Key factors in providing an appropriate space include:
    a. Privacy from others outside of the room.
    b. Comfortable seating.
    c. Adequate lighting – preferred lighting illuminates the faces of the participants. Back lighting and bright lights from windows can impeded video clarity.
    d. Computers or mobile devices should be on a secure, stable platform and as much as possible placed at an angle to allow the client and/or caregiver's faces to be visible to the therapist.

KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

4. I understand that in the event of technical issues, the therapist (or another KKP staff) will reach out via telephone or instant message on the telehealth platform in order to troubleshoot the issues. KKP will make every effort to resolve technical issues, however I understand that they have no control over issues that arise from technology and/or internet/cellular issues on my end.

5. I understand that it is the policy of KKP to never record telehealth sessions without my express consent and notification as to how the information is to be stored, encrypted, protected, and accessed. Furthermore, I understand that I am not to record the sessions without first discussing this with the therapist and the therapist agreeing in writing, and I agree to not share any recording or portion of a recording with the general public.

Signature of Client and Parent/Guardian: _____

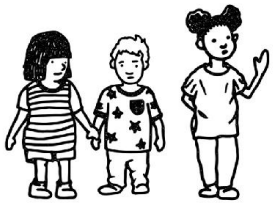
Name of Parent/Legal Guardian: _____ **Date:** _____

Parent/Guardian Email: _____ **Cell:** _____

Signature of Clinician: _____

Name of Clinician: _____ **Date:** _____

Clinician Cell: _____



KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

AUTHORIZATION TO EXCHANGE HEALTH INFORMATION PRIMARY CARE PHYSICIAN

The purpose of this HIPAA consent is to release or obtain electronic protected health information concerning the above-named client. Health information may relate to my past, present or future physical or mental health condition, the provision of my health care, or payment for my health care services.

1. **The person whose information may be used, disclosed, or exchanged is:**

   Name: _____

   DOB: _____

2. **The information may be disclosed to/exchanged with:**

   ☐ Any provider
   ☐ Only the Entity specified below
   Entity is: ☐ Configured for electronic exchange
   ☐ Not configured for electronic exchange

   External Exchange Entity: _____

   PCP Status: ☐ Client Has a PCP ☐ Client does not have a PCP

   Physician Name: _____

   Practice Name: _____

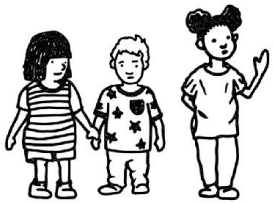
   Address: _____ PCP Fax: _____

   City/State/Zip: _____ Phone: _____

3. **The information that may be disclosed/exchanged includes all records of diagnosis and treatment. Disclosures of psychotherapy notes is not permitted.**
   Additional disclosure limitations:

   _____

   _____



KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

4. **This information is permitted to be disclosed/exchanged for treatment purposes only.** Additional details surrounding the purpose of information disclosure/exchange:

   _____

   _____

5. **The persons or organizations receiving any disclosure of this information will be permitted to re-disclose any information received based upon the consent to organizations or individuals providing treatment to the client.** I understand that Kinder Konsulting & Parents Too, Inc. cannot guarantee that the Recipient will not re-disclose my health information to a third party that may not be subject to federal laws governing privacy of health information.

6. **Consent:**
   - ☐ I GIVE CONSENT for protected health information exchange
   - ☐ I DENY CONSENT for protected health information exchange

   Effective: _____

   Expires: _____ or upon discharge

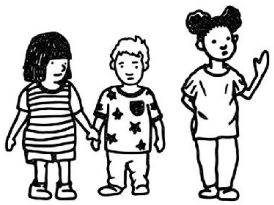
7. **I understand that this permission may be revoked.** I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given. I further understand that I must provide any notice of revocation in writing to the Privacy Officer at Kinder Konsulting & Parents Too.

8. **I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Kinder Konsulting & Parents Too, Inc.**

I am the person or parent/legal guardian of the person whose records will be used, disclosed, or exchanged. I give permission to use, disclose, and exchange records as described in this document.

Signature of Client and Parent/Guardian: _____
Name of Parent/Legal Guardian: _____ **Date:** _____
Parent/Guardian Email: _____ **Cell:** _____

Signature of Clinician: _____
Name of Clinician: _____ **Date:** _____
Clinician Cell: _____



KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

AUTHORIZATION TO EXCHANGE HEALTH INFORMATION

The purpose of this HIPAA consent is to release or obtain electronic protected health information concerning the above-named client. Health information may relate to my past, present or future physical or mental health condition, the provision of my health care, or payment for my health care services.

1. **The person whose information may be used, disclosed, or exchanged is:**

   Name: _____

   DOB: _____

2. **The information may be disclosed to/exchanged with:**

   Entity/School Name and Address: _____

   Fax: _____ Phone: _____

3. **Location of Services:**
   - ☐ I GIVE Consent for my child to receive services in the school/daycare that he/she is attending.
   - ☐ I DENY Consent for my child to be seen in the school/daycare. This consent is for Exchange of Information ONLY, and not for services to be conducted at this location.

4. **The information that may be disclosed/exchanged includes all records of diagnosis and treatment. Disclosures of psychotherapy notes is not permitted.**
   Additional disclosure limitations:

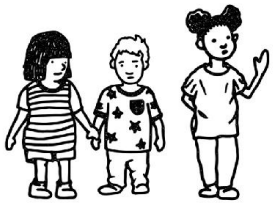
   _____

   _____

5. **This information is permitted to be disclosed/exchanged for treatment purposes only.**
   Additional details surrounding the purpose of information disclosure/exchange:

   _____

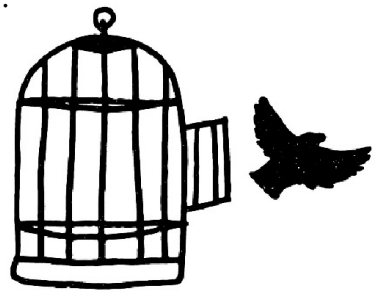
   _____



KINDER
KONSULTING

CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

6. **The persons or organizations receiving any disclosure of this information will be permitted to re-disclose any information received based upon the consent to organizations or individuals providing treatment to the client.** I understand that Kinder Konsulting & Parents Too, Inc. cannot guarantee that the Recipient will not re-disclose my health information to a third party that may not be subject to federal laws governing privacy of health information.



7. **Consent:**
   - ☐ I GIVE CONSENT for protected health information exchange
   - ☐ I DENY CONSENT for protected health information exchange

   Effective: _____

   Expires: _____ or upon discharge

8. **I understand that this permission may be revoked.** I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given. I further understand that I must provide any notice of revocation in writing to the Privacy Officer at Kinder Konsulting & Parents Too.

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Name of Clinician: _____ **Date:** _____
Clinician Cell: _____