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**As a benefit of the partnership between Russellville Independent Schools and LifeSkills, emergency screenings and ongoing services are available on site for all students at no direct cost to the family. Completion of this form provides helpful information in the event of an emergency screening by one of our trained mental health professionals. If school staff request an emergency screening for your child, a mental health professional will attempt to reach out to you at the time to provide information on the screening and any follow up recommendations. If you are interested in ongoing counseling services for your child, an appointment can be scheduled for an initial intake to begin those services at that time.**

**Mental Health Questionnaire and Consent School year 2023-24**

Student’s Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is your child currently seeing a mental health provider? (circle one) Yes or No
	1. If yes, who is their provider? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. If no, would you like LifeSkills to contact you to begin services for your child?

(circle one) Yes or No

1. Past Mental Health diagnosis and/or treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is your child prescribed medication for any mental health conditions? If yes, please indicate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other individuals who you give permission for us to communicate with about your child in case of emergency screening. (Please note, we will always attempt to reach the parent/guardian first)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_ Contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_ Contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*It is the guardian’s responsibility to notify the school in writing if the abuse contacts or information changes. I also acknowledge receipt of LifeSkills Notice of Privacy Practices.*

**School based consultation permission for treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am the legal \_\_ parent \_\_guardian \_\_client and I do herby grant my permission for the staff of LifeSkills, Inc. to render treatment and/or services to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Furthermore, I certify that I have full legal right to grant such permission.

**Informed Consent Disclosure**

You are assured confidentiality at LifeSkills, Inc. This is the foundation on which we build our trust with you, and we value it highly. We will not share information about you (or those for whom you have responsibility) without your knowledge. Whenever it is necessary to share information with anyone outside of LifeSkills, we will discuss that with you and have you give permission to release such information by signing an “Authorization to use or disclose Protected Health Information” form indicating the specific information to be released and to whom it is to be released. As noted above there are some conditions when your therapist is **required by law** to release confidential information about you with or without your permission. They include the following:

1. If your therapist has reasonable cause to believe that you intend to hurt yourself or someone else.

2. If your therapist has knowledge of or suspects a child has been abused or neglected.

3. If your therapist has knowledge of or suspects an adult who is vulnerable due to an emotional, intellectual, or physical disability has been the victim of abuse, neglect or exploitation.

4. If your therapist is subpoenaed to court and ordered by the judge to testify about you. The therapist will do his/her best to protect your right to confidentiality while complying with the court order.

**Release of Information for Billing Purposes**

In order to have services authorized and/or paid for by a third party (e.g., Insurance Co., Medicaid, Medicare, Department of Mental Health), it is necessary that we send certain information to them (e.g. diagnosis). In some cases, insurance benefits are managed by a “managed care company” who may require more detailed information and updates from time to time to continue certification or payment of services. When it is necessary to share such information, only information needed to certify services or access payment will be shared. Your signature below indicates that you understand this and consent to information being provided to any third-party payer source.

**As a benefit of the partnership LifeSkills has with Russellville Independent Schools, you will not receive a bill for services after your insurance has been billed.**

**Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consent valid for School year 2023-24 only.**