NORTH STAR COUNSELING | Permission Packet

Hello! Your child was recently referred to school counseling. School counseling is designed to provide a supportive and nurturing environment for your child's social and emotional wellbeing. We provide services through: individual sessions, peer group discussions, and other community or school-based services.

Counseling is provided by our awesome *North Star Counseling Team*. Our services are a collaborative and coordinated effort across credentialed and licensed staff from Mono County Office of Education & Mono County Behavioral Health who are experienced in supporting students with social, emotional, and/or behavioral concerns at school. Please visit our website **(www.northstarmono.org)** for more information about our providers and services.

All information in counseling sessions is *confidential* and is *only* disclosed with written permission except when the student is dangerous to themselves, others, and/or is otherwise required by law. You are always welcome to get in touch with your child's provider to inquire about general progress.

If you would like to grant permission for you and your child to be contacted by a mental health professional and begin the process of participating in counseling, please thoroughly fill out all the forms so we can work together to support your student. If you have any questions or would like any. help, please call 760-934-0031 x141. Thank you! :)

! School Staff or Parent&Guardian!

Please return this permission packet to your school's front office or scan+send to northstar@mono.ca.gov

Thank you!

BRIGHT FUTURES TOOL FOR PROFESSIONALS

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1			
2. Spends more time alone	2			
3. Tires easily, has little energy	3			
4. Fidgety, unable to sit still	4			
5. Has trouble with teacher	5			
6. Less interested in school	6			
7. Acts as if driven by a motor (restless or difficult to keep up with)	7			
8. Daydreams too much	8			
9. Distracted easily	9			
10. Is afraid of new situations	10			
11. Feels sad, unhappy	11			
12. Is irritable, angry	12			
13. Feels hopeless	13			
14. Has trouble concentrating	14			
15. Less interested in friends	15			
16. Fights with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Is down on him or herself	19			
20. Visits the doctor with doctor finding nothing wrong	20			
21. Has trouble sleeping	21			
22. Worries a lot	22			
23. Wants to be with you more than before	23			
24. Feels he or she is bad	24			
25. Takes unnecessary risks	25			
26. Gets hurt frequently	26			
27. Seems to be having less fun	27			
28. Acts younger than children his or her age	28			
29. Does not listen to rules	29			
30. Does not show feelings	30			
31. Does not understand other people's feelings	31			
32. Teases others	32			
33. Blames others for his or her troubles	33			
34. Takes things that do not belong to him or her	34			
35. Refuses to share	35			

Consent to Treat

Purpose
I would like services for myself or my child from the North Star Counseling Team and/or its contracted providers. I understand this document contains information about services that may be provided to me or my child. I have the right to speak with a provider about the information in this document and ask questions to understand this information.

My Rights
I was informed of my/my child's rights as a client. I understand that I can access consumer rights document containing my/my child's rights as a client at northstarmono.org. I understand that if my child is receiving services, in some instances, the provider may not be able to share information with me about them unless my child permits them to do so.

Privacy Practices
I acknowledge the North Star Counseling Team Notice of Privacy Practices, which has information about how my/my child's private health information may be used and disclosed under the law. I understand that in certain circumstances, data must be disclosed. For example, mental health and substance use providers are mandated to report if there is a reasonable suspicion of child, elder, or dependent adult abuse or neglect, if there is a threat to my/my child's physical safety; or if there is a threat to the safety of others. I understand that if my child is receiving services, in some instances, the provider may not be able to share information with me about them unless my child permits them to do so.

Services
I understand that the services may focus on mental health issues. I am aware my/my child's information and records may be shared between mental health and substance use programs and providers to provide treatment to the extent permitted by law.

Risks and Benefits of Services
I understand behavioral health services may have risks and benefits. I am aware that mental health services may involve discussing challenging aspects of my or my child's life and making changes to psychiatric medication I or my child may take and/or substance use treatment. I or my child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. I am also aware mental health services have been shown to have benefits. For example, psychotherapy and/or substance use treatment may lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Psychiatric medication may alleviate symptoms of mental health issues. I understand there are no certainties about what I or my child will experience as I or my child receive services and how successful services will be. I understand behavioral health services require an investment of time and effort from all involved and openness to what change and success may look like.

Services are Voluntary
I understand participation in mental health services is voluntary, except for certain situations where the North Star Counseling Team is legally required to provide services even if it is involuntary, such as 5150 psychiatric holds or conservatorships. I understand that even if a court orders me to participate in mental health services, I can still choose not to participate in services. I am aware that consequences may arise due to my decision not to participate in court-ordered services, which are my responsibility. I understand that I may speak with an attorney, probation officer, and/or Child Welfare Services worker to make the best decision regarding participating in court-ordered services.

Consent to Treat

Eligibility for Services
Eligibility for mental health services is determined by a combination of laws, regulations, and local policies. I will then be given referrals to other service providers, as appropriate, that may meet my or my child's needs.

Service Providers:
I understand that providers come from different educational and professional backgrounds and have various experience levels and licensure. They only provide services that are allowed by law for their specific education, experience, profession, and licensure. I understand that the North Star Counseling Team may utilize some unlicensed professionals who are in the process of completing their requirements for clinical licensure but who are authorized by law to provide mental health services under the supervision of a licensed mental health professional. I understand I or my child may benefit from some of these individuals, who will clearly identify themselves and their supervising provider/clinician. I understand I may call the supervising licensed clinician and North Star Counseling program coordinator if I have any questions about this arrangement.

Availability of Providers and Crises/Emergencies
I understand providers are generally available during regular school hours, Monday through Friday, 8 a.m. to 4 p.m., except during county holidays. I understand that some programs have different hours of availability. For non-urgent matters after-hours, I understand I or my child can leave messages in the provider's confidential voicemail or contact Mono County Behavioral Health after-hours telephone service (800-687-1101). I understand that Mono County handles its crisis through the 911 system. For emergencies, I understand my family, or I should call 911.

Change of Clinician/Provider
I understand requesting a change of provider does not guarantee a change, and significant administrative or treatment issues may not make the transition possible. I understand a supervisor or manager will provide me the reason(s) the change is not possible.

Fees and Billing Medi-Cal, Medicare, and/or Insurance
I understand that all services provided by the North Star Counseling Team have been funded by a grant from the Mental Health Services Oversight and Accountability Commission until 2026. This grant provides mental health services and familial support for all eligible school-age students residing within Mono County at no cost.

Complaints and Grievances
I understand I may file a complaint or grievance if I am dissatisfied with the services I or my child receive from the North Star Counseling Team and its contracted providers. I understand I or my child will not be subjected to any penalty for filing a complaint, grievance, or an appeal.

Informed Consent
By signing, I acknowledge that I understand the information contained in this document, and I agree to my receipt, or my child's receipt, of behavioral health services per the terms described above.

PRINT NAME: _____

CLIENT SIGNATURE: _____

PARENT/GUARDIAN/CONSERVATOR SIGNATURE: _____

Consent to Telehealth

I hereby agree to receive telehealth services and agree that this is an acceptable mode of delivering health care related services to me under the terms of this consent form. I understand and agree to the following statements regarding Telehealth:

- Telehealth services include video teleconferencing solutions to provide services to a client via electronic interactive audio and video telecommunication from a distant location. Telehealth services are considered face-to-face because the client is visually present. I understand that my provider will not be physically in my presence.
- Telehealth services may be provided to me for evaluation, diagnosis, management, and treatment.
- The treating provider performing the examination or treatment will keep a record of the consultation in my electronic healthcare record.
- All the information discussed via telehealth is held to the same privacy standards as that of an in-person appointment.
- There are risks, benefits, and consequences associated with telehealth, 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.
- When using my personal electronic device, the North Star Counseling Team has no control or authority over protecting the health information that may be stored within my device. I understand that data held within my device may be at risk, for example, if lost or stolen.
- All information disclosed within sessions and written records of those sessions are confidential. They may only be disclosed to people with written authorization where the disclosure is permitted and/or required by law. Audio/visual recording may be allowed with a separate written consent. Such recordings are for staff training purposes only, are not part of the medical record, and are destroyed after intended use.
- Although my provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency, I understand that my provider will be unable to render in-person emergency assistance if I experience a crisis during a telehealth session.
- I have a right to access covered services in person. I understand that non-medical transportation benefits are available for in-person visits.

PRINT NAME: _____

CLIENT SIGNATURE: _____

PARENT/GUARDIAN/CONSERVATOR SIGNATURE: _____

Consent to Email

I hereby agree to receive communication through email under the terms of this consent form. I understand that:

- If my email address changes, I should inform the North Star Counseling Team immediately. I understand that if I don't notify the North Star Counseling Team, providers may continue to email my previous address under this consent, which may result in a breach of confidentiality.
- When using my personal electronic device, the North Star Counseling Team has no control or authority over protecting the health information that may be stored within my device. I understand that data held within my device may be at risk, for example, if lost or stolen.
- Email is not appropriate for urgent or emergency situations. Providers cannot guarantee that any message will be read and responded to within a proper response period.
- Email is not inherently secure and may be intercepted by a third party. Providers will use reasonable means to maintain the security and confidentiality of email information sent and received. Providers and the North Star Counseling Team are not liable for any breach of privacy caused by the client or any third party.
- Depending on the service I use for emails, the messages sent may not be encrypted and, therefore, could be intercepted by other people. I agree to accept that risk by sending emails.
- I am under no obligation to communicate with the North Star Counseling Team or my providers via email, and if I have any concerns about sharing via email, I should not do so.

PRINT NAME: _____

CLIENT SIGNATURE: _____

PARENT/GUARDIAN/CONSERVATOR SIGNATURE: _____

Consent to Text

I hereby agree to receive communication through text under the terms of this consent form. I understand that:

- If my phone number changes, I should inform the North Star Counseling Team immediately. I understand that if I don't notify the North Star Counseling Team, providers may continue to text my previous number under this consent, which may result in a breach of confidentiality.
- When using my personal electronic device, the North Star Counseling Team has no control or authority over protecting the health information that may be stored within my device. I understand that data held within my device may be at risk, for example, if lost or stolen.
- Texting is not appropriate for urgent or emergency situations. Providers cannot guarantee that any message will be read and responded to within a proper response period.
- Providers will use reasonable means to maintain security and confidentiality of text information sent and received. Providers and Mono are not liable for any breach of privacy caused by the client or any third party.
- My cellphone carrier may charge me fees for the sending and receipt of texts.
- I have the right to opt out of the receipt of text messages at any time by replying "STOP" to any message I received from the North Star Counseling Team or my provider.
- The messages sent may not be encrypted depending on the service I use for text messaging. They could be intercepted by others, and I agree to accept that risk by text messaging.
- I am not obligated to communicate via text message with the North Star Counseling Team or my providers. I should not do so if I have any concerns about communicating via text.

PRINT NAME: _____

CLIENT SIGNATURE: _____

PARENT/GUARDIAN/CONSERVATOR SIGNATURE: _____

MONO COUNTY CHILDREN'S SYSTEM OF CARE (CSOC)
MULTI-AGENCY CONSENT AND AUTHORIZATION
TO DISCLOSE, EXCHANGE AND USE INFORMATION
AND RECORDS

Client Name: _____ Date of Birth: _____

☐ Parent/Legal Guardian ☐ Child

I authorize the identified agencies or people checked (X) below to use, disclose, and exchange relevant information, both verbally and in writing for the limited purpose of developing and providing appropriate and coordinated services to me, or the child named on this consent form, in a manner that assures the maximum protection of my individual privacy and confidentiality. This includes medical and mental health information, excluding psychotherapy notes.[1]

At a later date, after I have signed this release, I may check (X) and date additional boxes to allow other persons/ agencies to share my (or my child's) information, in the same manner and for the same purposes as described above.

Mono County Agencies:

X	Name	Date	Initials
	Social Services, including, but not limited to: Child and/or Adult Protective Services, Benefit Assistance Programs, and Housing		
	Probation		
X	Behavioral Health, including, but not limited to: Substance Use Disorder (SUD) program, and Mono County Wraparound Program		
	Public Health, including, but not limited to: Women Infant and Children (WIC) Program, and Children's Medical Services (CMS)		
	Superior Court, including, but not limited to: Family Law Facilitator		
	Child Support Services		
	District Attorney's Office, including, but not limited to: Victim-Witness Services		

[1] This form authorizes the release of Treatment Plans, Summary of Progress, Medications, and Diagnoses. This form does *not* authorize the release of "psychotherapy notes," defined by HIPAA as "notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record."

	OTHER (fill in name):		

Health and Education:

X	Name of Agency/Person/Service Provider	Date	Initials
X	Mammoth Unified School District		
X	Eastern Sierra Unified School District		
	Mono County First 5, including, but not limited to: Home Visiting, Peapod		
X	Mono County Office of Education (MCOE), including, but not limited to: Foster Youth Services Program Coordinator Program (FYSCP), Early Start, Jan Work Community School, and Childcare programs, Alternative Education, Pre-School		
	Toiyabe Indian Health Services		
	Mammoth Hospital, including, but not limited to: Pediatrics, Family Medicine, Emergency Room, Labor and Delivery, Behavioral Health		
	Kern Regional Center		
	Northern Inyo Hospital		
	Substance Use Disorder (SUD) Treatment program/facility (separate from Mono County Behavioral Health (fill in name):		
	Therapist, separate from Mono County Behavioral Health (fill in name):		
	OTHER (fill in name):		
	OTHER (fill in name):		

Community Agencies and Other Partners:

X	Name	Date	Initials
	Wild Iris Family Services & Counseling Center		
	Court Appointed Special Advocates (CASA)		
	Community Services Solutions (CSS)		
	Housing Support Program (fill in name):		

	Marine Corp Mountain Warfare Training Center (MWTC) including, but not limited to: Family Advocacy Program (FAP) and Child Development Center (CDC)		
	OTHER (fill in name):		
	OTHER (fill in name):		
	OTHER (fill in name):		

Tribal:

X	Name	Date	Initials
	ICWA Representative (fill in name):		
	Owen's Valley Career Development Center, including, but not limited to: Tribal Temporary Assistance for Needy Families (TANF), Early Head Start		
	OTHER (fill in name):		

Unless otherwise stated, I authorize the release, disclosure, and exchange of information and records as follows:

- Name and other personal identifying information
- Type of services I am seeking and/or receiving by service provider
- Evaluations, Assessments, Summaries of Treatment, and Progress Updates/Reports
- Mental Health Treatment[2] (Treatment Plans, Summary of Progress, Medications, Diagnoses)

Note about Alcohol & Substance Use Disorder (SUD): I authorize the agencies checked on the first two pages to use, disclose and exchange all information related to my substance use disorder diagnosis, information about my attendance at treatment sessions, my cooperation with the treatment program, prognosis, urinalysis and/or breathalyzer results, treatment plan, and discharge status.

Notes about Medical Records:
HIV Information: If HIV information is part of a client's medical record, it may be included in records.

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I authorize the use and/or disclosure of my individual information as described for the purposes listed above. I understand my right to refuse to sign this authorization. Not signing this form will not affect my ability to receive services, but it may impact the ability of the service providers I am working with to collaborate and streamline their work with me. The purpose of this authorization is to minimize duplication and maximize coordination of services and treatment.

I understand this authorization is effective immediately (on the date signed below), and that I may revoke the authorization at any time, except to the extent that a provider has already taken action in reliance on it, by submitting a written revocation using the form set forth below (or similar language) to the staff who signed this form. If not revoked earlier, this authorization expires on _____ or two (2) years from the date of signature.

I understand that recipients of my mental, alcohol, and/or drug treatment records are prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.

_____ _____

Signature of Client **Signature of Parent** (or, **Guardian/Representative*)**

Date Signed: _____

** If an authorized representative (other than the client) signed this form, staff initials confirm that staff verified (1) The identity a authority to sign on behalf of the client:* _____

(staff initials)

Name of Interpreter (if applicable):_____ Language (if other than English):_____

☐ I, _____ offered client a copy of this form. ☐ Copy given on _____ ☐ Client declined

(Staff Name) *(Date)*

_____ _____

Signature of Staff Date

REVOCATION

This is for when or if you want to make changes later.

I hereby revoke this Authorization on this day of: _____

Date

_____

Signature of Client / Parent/Guardian/Representative

To Recipient Agencies: This information is protected by state and federal laws and shall not be disclosed to any person or entity not included as an authorized recipient on this form without a new authorization from the client, unless otherwise provided by law.

To Alcohol and/or Drug Treatment Providers: This information has been disclosed to you from records protected by Federal and State confidentiality rules. You are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by applicable law. A general authorization for release of medical or other information is NOT sufficient for this purpose. Federal Law restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.