# Application

Please check the type of trauma the child has experienced:

\_\_\_\_Witnessed domestic violence

\_\_\_\_Physical abuse

\_\_\_\_Sexual abuse

\_\_\_\_ Neglect

\_\_\_\_ Other: Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (First, Last, MI):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Has the Athlete attended counseling before? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, when, where, and how long ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# ATTENTION: Please note the information contained in this document is CONFIDENTIAL. If sending confidential information via email, please be advised Family Counseling Service’s email is not encrypted and will not take responsibility for actions by others that result in HIPAA violations.

#

Athlete’s Name: Age: \_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_

 Last First

Gender (Check One) [ ]  Male [ ]  Female [ ]  Nonbinary [ ]  Other:\_\_\_\_\_\_\_\_\_\_

Preferred pronouns:\_\_\_\_\_\_\_\_\_

Ethnicity: \_\_\_ Shirt Size \_\_\_\_\_\_\_\_\_\_

Home Address of Child

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address City State Zip

Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First

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

 Street City State Zip

Contact Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_

If Athlete lives with ***someone other than legal guardian*** this information is required:

Name of person Athlete lives with \_\_\_\_\_\_ \_Phone:(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First

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

 Street Address City State Zip

**Emergency Contact (person legally responsible for Athlete):**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Athlete: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime Phone Number: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Evening Phone Number: ( ) \_\_\_

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

 Street Address City State Zip

**Dietary/Allergies**

Any dietary restrictions? ex: lactose intolerant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Restrictions

Explain any restrictions to physical activity or special needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain any other known restrictions participating in team sports: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional information for health care staff at the Sports Therapy : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please use this space to provide any additional information about the Athlete’s emotional, or mental health (i.e. depression, anxiety, PTSD) needs which the Sports Therapy staff should be aware. **This information is important to ensure that your Athlete receives appropriate care**.

 \_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_

Please have the Athlete explain in the athlete’s own words why they want to attend Sports Therapy (this question may be asked in follow –up phone interview):

 \_\_\_\_\_\_\_\_\_\_\_\_

Please provide information regarding Athlete’s exposure to domestic violence, sexual abuse, physical abuse or neglect. Provide as much information as you can, including perpetrator, what type of abuse was experienced/witnessed, when and where abuse occurred, and when/how family left the situation. ***Please indicate when this was reported to law enforcement, and if there is a pending court date***. This helps us to understand more about your Athlete’s specific situation and ensure proper authorities have been contacted.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If more space is needed you may attach additional pages.

# Application for Service and General Consent

Athlete’s Rights and Responsibilities

The Athlete and the provider have a responsibility to each other to ensure that the best possible service is provided and appropriately used.

# Each Athlete has the right to the following:

* Considerate and respectful service.
* Service provided by qualified personnel.
* A reasonable response to their request for service and reasonable continuity of care.
* To lodge a complaint, verbally or in writing, when he/she feels any of their rights to service have been violated by a representative of the agency. The executive director will return a decision to you within 14 days of receiving your complaint. You may appeal the decision, verbally or in writing, to the Family Counseling Service Board of Trustees. The receptionist will provide you the phone number and address of the current board president. The board of trustees will return a decision to you within 14 days of receiving your appeal. Forms are available from any staff member.
* Freedom from retribution or other adverse consequences as a result of filing a grievance.
* Service without discrimination as to race, religion, age, marital status, gender, national or ethnic origin, or sexual orientation.
* To participate in the development of their treatment plan.
* To accept or reject any treatment plan.
* Family Counseling Service (FCS) policies, such as eligibility for service, regulations and hours of service, and fee information.
* Assistance in locating the appropriate service when continuity of care cannot be provided by FCS.
* To examine and receive an explanation of their bill for service, regardless of the payment source.
* To receive a Copy of the Athlete Rights and Responsibilities at the time service begins.
* To be informed of the name, date, title and professional credentials of any person providing their service.
* To review their case record in accordance with FCS policy.

**Each Athlete has the Responsibility to:**

* Accept or refuse service.
* Direct grievances, concerns and recommendations for change, verbally or in writing to your therapist, the executive director, or other FCS staff. Grievance or complaint forms are available from the reception area staff, your counselor, or any FCS employee.
* Keep all scheduled appointments or give a 24-hour notice of cancellation. FCS reserves the right to refuse to schedule appointments for those who have not appeared for two or more appointments. FCS will charge Athletes a full fee for appointments where less than 24 hours’ notice is not given.

Signature of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Athlete: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Athlete Confidentiality**

The clinical staff of FCS are required by law, professional ethics and standard agency practice to maintain Athlete confidentiality. The confidentiality of Athlete records maintained by this program is protected by federal law (42 USC 290 dd-3 and 42 USC 290ee-30) and federal regulation (42 CFR Part 2). **Generally**, the agency may not say to a person outside the agency that an Athlete attends counseling or treatment at the agency, or may not disclose any information identifying the Athlete as an Athlete **unless:**

* The Athlete consents in writing, or
* The disclosure is allowed by court order, or
* The disclosure is made to medical personnel in a medical emergency, or to a qualified person for research, audit or program evaluation, or
* The Athlete commits or threatens to commit a crime either at the agency or against any person who works for the agency
* The Athlete is a danger to themselves or others and/or discloses abuse to vulnerable populations

**and**, if an Athlete threatens suicide or grave bodily harm to another person, we may choose to notify the appropriate law enforcement agencies and/or the intended victim. *Whenever there is a reason to believe that a child or elderly person is subject to abuse, we are required by law to inform appropriate law enforcement and/or welfare agencies.*

**and**, if a court of law issues a legitimate subpoena, we are required by law to provide the information specifically described in the subpoena. If an Athlete is in therapy or being tested by order of a court of law, the results of the treatment or tests ordered may be revealed to the court by consent of the Athlete.

Signature of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Athlete: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release and waiver of liability and indemnity agreement.**

I further agree to indemnify, protect, defend, and hold harmless Family Counseling Service Sports Therapy Program, The Boys and Girls Club, and Amazing Athletes and their directors, officers, employees, volunteers, and/or agents from and against any cost, damage, expense, claim, or liability caused by or arising out of my use of, presence at, the facilities that host Family Counseling Service Sports Therapy Program, The Boys and Girls Club, and Amazing Athletes, including any injury to or death of any person, any damage to any real or personal property on or about the facilities that hosts Family Counseling Service’s Sports Therapy and The Boys and Girls Club, Amazing Athletes and any attorney’s fees and/or costs arising out of this Agreement.

I, the undersigned, hereby waive any and all claims that I or my heirs may have against the directors, officers, employees, volunteers, and/or agents of Family Counseling Service Sports Therapy, The Boys and Girls Club, Amazing Athletes for any injuries or property damages which may arise while my child participated in Family Counseling Service Sports Therapy, The Boys and Girls Club, and Amazing Athletes. I acknowledge that this waiver includes any claim for wrongful death, personal injury, or property damage caused by or arising out of the negligence of Family Counseling Service Sports Therapy, The Boys and Girls Club, and Amazing Athletes, or their directors, officers, employees, volunteers and/or agents.

Signature of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Athlete: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for use of photo**.

I hereby authorize Sports Therapy by Family Counseling Service, The Boys and Girls Club, and Amazing Athletes, for any purpose whatsoever, any photograph (including digital media and videotape) taken during Sports Therapy by Family Counseling Service, The Boys and Girls Club, and Amazing Athletes that contains my child’s likeness.

Signature of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Athlete: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Consent for Treatment**

I have chosen to receive mental health services for myself and/or my child, foster child or ward of the State from Family Counseling Service of No Nv (FCS). My decision is voluntary and I understand that I may terminate these services at any time, unless my participation has been mandated by a Court of Law.

**Nature of Mental Health Services**

I understand that during the course of treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will free better after completion of treatment.

**Compliance with treatment plan**

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Two consecutive/nonconsecutive "No Shows" and/or late cancellations will be grounds for termination of services, as well as failure to follow my treatment plan in any form. I agree that by not making any contact (calling, emailing, texting to schedule a session) with my therapist for over one month will result in my file being closed. I understand that I am welcome to reconnect and request therapeutic services again; however, services are not guaranteed and you may be placed on a waitlist.

**Supervision**

I understand there are certain circumstances which may require FCS provider(s) to receive supervision. These circumstances include, but are not limited to the following:

* State licensure regulations may require my therapist or service provider to receive ongoing supervision
* Accreditation organizations, as well as insurance companies, may require that my treatment plan be reviewed
* The standards of care which guide most mental health professional recommend that my treatment plan be reviewed
* Other special circumstances, such as preparation to testify in court

**Emergencies**

I understand I may reach my FCS provider at 775-329-0623 or 775-899-2696. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life threatening emergency situation, I may call 911.

I have read and understand all of the above.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minor’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_