The Watson Institute

STAT 2019

(Summer Therapeutic Activities for Teens)

STAT runs Monday through Friday at both locations from 9:00 am until 3:00 pm for a period of FOUR weeks.
Daily and consistent attendance is REQUIRED for acceptance into the program.

APPLICANT NAME: _____

NICKNAME (IF APPLICABLE):_____

MALE ☐ FEMALE ☐

DATE OF BIRTH: _____ AGE AT START OF CAMP: _____

PARENT/GUARDIAN PHONE NUMBER: _____

PARENT/GUARDIAN NAME(S): _____

PARENT/GUARDIAN EMAIL ADDRESS:

_____

MAY WE CONTACT YOUR VIA EMAIL TO DISCUSS YOUR TEEN'S STAT APPLICATION? YES NO

ADDRESS: _____

CITY, STATE, ZIP: _____

COUNTY WHERE YOU RESIDE: _____

STAT 2019 WILL BE OFFERED AT ONLY ONE (1) LOCATION. THE LOCATION AND SESSION TIMES FOR 2019 ARE LISTED BELOW.

THIS YEAR, STAT WILL BE OFFERED IN THE SEWICKLEY LOCATION ONLY:

[ ] Session 7/8/19 – 8/2/19 @ SEWICKLEY LOCATION

EDUCATION:

School district: _____

Name of school building that teen attends:_____

Will your teen receive Extended School Year Funding (ESY) in 2019? ___ Yes ___ No

Has your teen's school district approved STAT as his/her ESY placement for 2019? __ Yes ___No ____ Unknown

******You must include a copy of your teen's most recent IEP if planning on using ESY funding***

MEDICAL INFORMATION:

Is your teen on any medications? ___ Yes ___ No

Medications to be administered during STAT? ___ Yes ___ No

If yes, schedule: _____

Prescribing Physician's Name: _____

Phone Number: _____

Dietary Restrictions:

Does your teen have any dietary restrictions or allergies? ___ Yes ___ No

If so, please name restriction/allergy? _____

_____

What type of daily transportation will your teen be using to arrive/depart from STAT?

*(The Watson Institute **does not** provide daily transportation to/from STAT for any teen)*

District School bus Parent transporting

EMERGENCY CONTACTS (OTHER THAN PARENT OR GUARDIAN):

Name: _____ Phone: _____

Name: _____ Phone: _____

ADDITIONAL INFORMATION:

Teen's strengths/particular interests

_____

_____

_____

Will you be on vacation during this summer? ___ Yes ___ No when? _____

Current Communication Difficulties: (please circle all that apply)

None Peer Conversations Adult Conversations

Pragmatics Language processing Delayed Language

Current Non-Compliance Issues:

Does your teen have behavior issues related to:

___ Bolting ___ Adult Physical Aggression ___ Peer Physical Aggression

Does your teen have a behavior plan per his/her school district? Yes No

(If yes, please include copy of the behavior plan)

Other behavioral Issues (please provide): _____

Self Care Skills:

Does your teen wear a diaper during the day?	Yes	No
Is your teen independent with wiping after a bowel movement?	Yes	No
Does your teen have urination accidents that requires cleanup?	Yes	No
Does your teen have bowel movement accidents that requires cleanup?	Yes	No

Is your daughter independent with all tasks associated with menstruation needs/care?

Yes No Not Applicable

(Please note that due to the nature of Camp STAT, staff cannot provide any type of hands-on assistance with diapering, toileting/wiping, or menstruation needs All STAT teens must be independent with these tasks).

Stat

THE WATSON INSTITUTE
TREATMENT CONSENT/FINANCIAL AGREEMENT/AUTHORIZATION TO RELEASE INFORMATION

Consent for Psychological Services and Treatment

I hereby consent for my child to receive an evaluation and/or therapeutic services from The Watson Institute. I understand that the nature and goals of my child's treatment will be agreed upon by myself and my child's treatment team, and will be documented in a treatment plan. I am aware that the practice of behavioral and psychological intervention is not an exact science and I acknowledge that there are no guarantees as to the outcome of any treatments that my child will receive.

Assignment of Benefits

In the event my child is entitled to medical or mental health benefits of any type arising out of any insurance policy or from any person or organization who is or may become liable to my child to provide such benefits, I hereby assign such benefits to The Watson Institute. Such insurance includes but is not limited to private commercial insurance and any governmental program such as Medicare or Medicaid. I certify that the information given regarding my child's insurance is accurate and current.

Financial Agreement

In consideration of services rendered by The Watson Institute, the undersigned individually obligates himself/herself and guarantees prompt payment of all charges incurred for services rendered to the patient when not covered by insurance carriers or others. Insurance co-payments and self –pay charges are due at the time of the visit. Payment will be made of any balance due and not paid by insurance carriers or third-parties within 30 days of final billing. If such payment is not received by The Watson Institute within 30 days of the date of final billing, finance charges may begin to accrue at the maximum rate allowable by law. If The Watson Institute does not receive such payment within 30 days of the date such balance is due, the bill may be turned over to an attorney or a collection agency, at which time the undersigned shall be liable for attorney's fees and/or collection agency's fees and expenses. The undersigned understands The Watson Institute has the right to examine credit bureau files for financial information regarding collection of unpaid debts.

Confidentiality & Release of Information

We will obtain your authorization, on an annual basis, for the release of any records. Information regarding your child will not be released in any form without your written permission, except in those circumstances required by law. Those who can access the records without specific approval include Watson employees in the course of their jobs.

Authorization to Release to the Insurance Company

I authorize The Watson Institute to release all or part of my child's medical record by telephone, by facsimile transmission, or in writing when required or permitted by law or governmental regulation, or as a condition for payment of charges from insurance carriers, third party reimbursers, utilization review bodies, welfare funds, or to our primary care physician or any physician, mental health professional, or agency responsible for continuing care. This authorization extends also to any organization acting on behalf or in place of the insurance companies. The Watson Institute and its employees who render services to my child are hereby released from any and all liability that may arise from the release of the information.

The undersigned certifies that he/she has read and understands the above and fully accepts all specified terms therein.

PATIENT NAME: _____ DOB: _____.
Print

_____

Client signature if age 14 or older Date

_____

Parent/Legal Guardian Signature (relationship to patient) Date

Watson INSTITUTE

Education Center
Sewickley
301 Camp Meeting Road
Sewickley, PA 15143
(412) 741-1800

Friendship Academy
255 South Negley Avenue
Pittsburgh, PA 15206
(412) 365-3800

LEAP Preschool
Training and Consultation
WISCA
200 Linden Avenue
Pittsburgh, PA 15215
(412) 781-1708

Education Center South
WISCA
230 Hickory Grade Road
Bridgeville, PA 15017
(412) 914-8800

PHOTO/VIDEO CONSENT FORM

The Watson Institute sometimes uses images of children in trainings we provide for our own staff or in trainings that we offer to other groups. We also utilize images and videos of children for marketing purposes and on our website. We will not photograph or videotape any child without your written permission. Choosing not to give your permission will not affect your child's services in any way. Please indicate your choice on each line below.

I _____ give permission for my child _____
(please print) (please print)

DOB: _____ to be:

Please check one on each line:

YES	NO	
[ ]	[ ]	Photographed
[ ]	[ ]	Videotaped

The Watson Institute may use materials:

YES	NO	
[ ]	[ ]	For use in interventions with the child/patient
[ ]	[ ]	For training purposes by the Watson Institute
[ ]	[ ]	For training of other groups
[ ]	[ ]	For marketing purposes by the Watson Institute
[ ]	[ ]	For use on the Watson Institute website
[ ]	[ ]	For instructional and therapeutic use during group sessions
[ ]	[ ]	For distribution to current group members

_____
Child's Signature (if 14 or older) Date

_____
Parent/Guardian's Signature Date

CAMP – SCHOOL CONTRACT

THE WATSON INSTITUTE
PSYCHOLOGICAL SERVICES
AUTHORIZATION FOR ACCESS, USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. Failure to provide all informant requested may invalidate this authorization.

Patient Name: Date of Birth:

Address: Telephone #:

Date(s) or Treatment: (Note: authorization is not valid prior to care being rendered.)
From date: To date:

The specific information to be disclosed from my medical/treatment records includes:

Treatment Plan, Data Summary, Open communication between Watson, the Camp and The School, School visit to the Camp sites.

Purpose of Disclosure: Cont. of Care

Individual(s) or organization(s) authorized to use or disclose the information:

[X] The Watson Institute Psychological Services, 301 Camp Meeting Road, Sewickley, PA 15143

[ ] Other:

Individual(s) or organization(s) authorized to receive the information:

Name: Telephone #:

Address:

PATIENT RIGHTS:
I understand that signing this authorization is voluntary, and The Watson Institute cannot deny me treatment for not agreeing to sign this authorization. I understand that I may see a copy of the information described on this form and that there may be a fee associated for copying. I understand that once the above information is disclosed it may not be under the control of The Watson Institute and may not be protected by federal privacy regulations, therefore there is a potential of unauthorized re-disclosure by the recipient. I understand that this authorization may be revoked by me at any time. I understand that if I do revoke the authorization, I must do so in writing and present my written revocation to be filed in my medical record, which will not apply to information that has already been disclosed in response to this authorization. If I have questions about the disclosure of my health information, I may contact the Privacy Officer of The Watson Institute. I hereby certify that I have read this authorization and agree to it terms.

I understand that my medical records may contain sensitive information relating to AIDS, HIV, psychiatric care, and or treatment for drug and/or alcohol. I give consent for use and disclosure of this type of information. (Please list exclusion, if any)

Signature: (Parent/Legal Guardian/Child) Relations to Patient Date

Signature of Witness Date

EXPIRATION: This authorization is valid for one year from the date of signature, unless the authorization is revoked by written notice.

THE WATSON INSTITUTE

PSYCHOLOGICAL SERVICES
AUTHORIZATION FOR ACCESS, USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. Failure to provide all information requested may invalidate this authorization.

Print Clients Name: _____ Date of Birth: _____

Individual(s) or organization(s) [ ] Authorized to disclose the information: [ ] Authorized to receive the information:

Name: **THE WATSON INSTITUTE** Telephone: **412-749-2889** Fax: **412-741-9021**

Address: **301 CAMP MEETING ROAD, SEWICKLEY, PA 15143**

Individual(s) or organization(s) [ ] Authorized to disclose the information: [ ] Authorized to receive the information:

Name: _____ Telephone #: _____ Fax: _____

Address: _____

Date(s) or Treatment: (Note: authorization is not valid prior to care being rendered.)

From date: _____ To date: _____

The specific information to be disclosed from my medical/treatment records includes:

_____Psychological/Psychiatric Evaluation
_____Treatment Plans
_____Progress Notes
_____Discharge Summaries
_____Medical History /Physical Exam
_____Medication History
_____On Going Two Way Communication

_____Other _____

Purpose of Disclosure: ____Continuity of Care _____

PATIENT RIGHTS:
I understand that signing this authorization is voluntary, and The Watson Institute cannot deny me treatment for not agreeing to sign this authorization. I understand that I may see a copy of the information described on this form and that there may be a fee associated for copying. I understand that once the above information is disclosed it may not be under the control of The Watson Institute and may not be protected by federal privacy regulations, therefore there is a potential of unauthorized re-disclosure by the recipient. I understand that this authorization may be revoked by me at any time. I understand that if I do revoke the authorization, I must do so in writing and present my written revocation to be filed in my medical record, which will not apply to information that has already been disclosed in response to this authorization. If I have questions about the disclosure of my health information, I may contact the Privacy Officer of The Watson Institute. I hereby certify that I have read this authorization and agree to it terms.

I understand that my medical records may contain sensitive information relating to AIDS, HIV, psychiatric care, and or treatment for drug and/or alcohol. I give consent for use and disclosure of this type of information. (Please list exclusion, if any)

_____
Client signature if age 14 or older Date

_____
Signature: (Parent/Legal Guardian/Child) Relationship to Patient Date

EXPIRATION: This authorization is valid for one year from the date of signature, unless the authorization is revoked by written notice.