UT Physicians
A Part of UTHealth

PATH
INTEGRATIVE FAMILY HEALTH

PATH Program Clinical Services Contract

The PATH Program is a unique day treatment program for children and adolescents with complex medical issues. We focus on providing integrative, family-focused care, and have a team of medical and behavioral health professionals working with your child. These professionals at least include a pediatrician or nurse practitioner, psychiatrist, psychologist or therapist, nurse, recreational therapist, and a teacher. Children and adolescents participating in our program range from ages 8-18 years, and are separated into smaller groups based on age and developmental level.

This form contains important information about our clinical services and professional policies. When you sign this form, it means that you are entering into an agreement with our program and services.

Consent for Medical Care and Treatment **Initials _____**

Knowing that I (the Patient) or the legal guardian (of the Patient) have (has) a condition requiring medical care, I hereby consent to such care including examinations, diagnostic procedures and medical treatment by the Patient's physician, their assistants, and consignees as may be necessary in their judgment. I acknowledge that no guarantees have been made as to the result of diagnostic procedures, medical treatments or examinations by UT Physicians clinicians.

The Patient is under the care and supervision of the Patient's attending physician and consultants selected by this physician. It is the responsibility of UT Physicians and its staff to carry out the instructions of these physicians.

Medication **Initials _____**

You are responsible for bringing your child's medications on the first day at PATH. All prescription medications should be in a container labeled by the pharmacist or the physician. All medications should be in their original containers. Medication will remain in a locked cabinet throughout the day and will be returned to you at the end the program, unless specified that medication needs to be returned at the end of each program day. Medication administration will be overseen by a trained medical professional.

Behavioral Health Services **Initials _____**

The PATH Program provides family-focused integrated care, with individualized treatment plans that aim to help children reach their highest level of functioning. As a part of our program, your child will receive a range of behavioral health services including psychiatry services and individual, group, and family therapies. Therapy services will be provided by trained clinicians, recreation therapists, clinical psychologists, psychiatrists, and/or trainees (practicum students, interns, fellows).

Clinicians at the Program use evidence-based treatments specifically designed for children and adolescents, as well as monitor your child's progress during and after treatment. As a part of your child's routine clinical care and ongoing program evaluation, you and your child will be asked to complete assessments at the beginning and end of treatment. During the program, your child will receive weekly individual and family therapy, and daily group therapy. In order for therapy to be successful, your child will be asked to work on goals and skills at home. Parent/caregiver involvement in PATH treatment is essential to help support your child.

There may be both benefits and risks to participating in therapies, as your child may be asked to share personal thoughts, feelings, and experiences that may have been unpleasant. This may bring up feelings of sadness, anxiety, or helplessness. Still, sharing feelings and experiences with trained providers can help to decrease

distressing emotions, promote positive ways of managing difficult emotions, improve problem-solving skills, and help to improve symptoms related to his/her medical condition. However, there is no guarantee that this is what every child will experience through therapy.

Educational Services **Initials _____**

During your child's stay in the program, your child will be provided with individualized educational programming with the goal of returning to school after leaving the program. A specialized instructional interventionist (teacher) will work with your child's home school and district to obtain up-to-date classroom assignments and homework. Our teacher will work with your child daily for 90 minutes to assist with their educational needs. The Program's teacher will also assist families with setting up specific accommodations at school that may be necessary for when your child returns to school.

Minors **Initials _____**

There may be times which will be determined by your child's treatment team on a case-by-case basis that your child will participate in activities outside of the clinic. For example, a PATH staff member may take your child to Children's Memorial Hermann to participate in ordered services (e.g., physical therapy, occupational therapy). At other times, your child may be accompanied by a staff member to walk around the hospital or to a nearby park (Memorial Hermann Park, Rice University) as a part of their therapy activity, or during drop-off and pick-up times.

Keeping your child safe is our priority. In the event of elopement (that is, if your child wanders or runs away from the clinic), our team will contact both you and authorized officials who are trained to help keep minors safe. If your child exhibits aggressive behaviors which become disruptive and/or a safety concern to the program, you will be contacted. In very rare cases, our team may decide it is necessary to restrain your child for safety. In this event, you will be contacted and given details.

Car Safety, Check-in and Check-out Procedures **Initials _____**

Parents and caregivers must adhere with Drop-Off and Pick-Up times. Check-in begins promptly at **7:30am and ends at 8:30am**. **Check-out begins promptly at 3:00pm and ends at 3:30pm**. It is important that you arrive on time.

Due to the high traffic in the loading dock, parents are responsible for ensuring their child follows car safety behaviors including immediately returning to the vehicle during drop-off and pick-up times. Please do not leave your child unattended for any reason.

Confidentiality **Initials _____**

Privacy is very important in behavioral health treatment. Please do not talk to your friends and family about other children or families you meet here. Please do not use cell phones or cameras here. Finally, your child will not be allowed to exchange contact information with other children in the program during PATH participation, including exchanging: phone numbers, home addresses, email addresses, Facebook or other social network contact information, etc.

In general, privacy of all communications between a patient and medical/behavioral health providers is protected by law, and your child's information can only be released to others with a parent or legal guardian's written permission. However, there are circumstances in which information concerning your child may be required to be released without your prior consent. These include if: 1) the child poses a serious danger to him/herself or others, 2) there is evidence to suggest abuse or neglect of a minor child, person with a disability, and/or older adult, 3) a court issues an order requiring release of records, and/or 4) a valid medical emergency occurs.

Patient Concerns **Initials _____**

Our staff strives to provide excellent care and service, and we hold ourselves to the highest personal and professional standards. If we fail to meet your expectations in any way, please do not hesitate to let us know as soon as possible. Rest assured that voicing a concern will never negatively affect the care and services we provide. If there is a problem, we want to correct it. Usually, a word to any staff member is all that is needed, but if you prefer, you may call Patient Relations at 713-486-1875 to speak confidentially with a patient representative, or you may email patientexperience@uth.tmc.edu. You also have the right to register a complaint with the Health Care Financing Administration, Texas Medical Board and/or Texas Department of Insurance.

Authorization for Use and Disclosure of Information **Initials _____**

I authorize UT Physicians to release any medical information including diagnostic, x-rays, test results, reports and records pertaining to any treatment or examination rendered to the Patient. I understand that this medical information may be used for any of the following purposes: diagnostics, insurance, legal and at times when the attending physician deems it necessary in order to ensure the best medical care on my behalf. I authorize UT Physicians and the Patient's physician(s) to disclose the Patient's health care information to any entity specified in UT Physician's Joint Notice of Privacy Practices. I further understand that any person(s) that receive(s) these medical records will not release any of the medical information disclosed by this authorization to any other person or organization without authorization signed by me for release of the information.

Declaration

I have read and understand the above agreements and authorizations. The terms and consequences of this document have been fully explained to me and I have signed it freely and without inducement. All of my questions have been fully answered.

_____ Patient/Legal Guardian Signature / Initials (must be over 18 years of age)	_____ Date/Time	_____ Interpreter Name and ID (if necessary)
_____ Print Name	_____ If Legal Guardian, state relationship to patient	
_____ Guarantor/Insured Signature / Initials (if different from above)	_____ Date/Time	_____ Print Name and Relationship to patient
_____ Witness Signature	_____ Print Name	_____ Date/Time