**Fort Thompson IHS School-Based Behavioral Health Clinic**

**Information Sheet**

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| **Who can use the School Based Services?**  All students who are eligible to receive services from the Indian Health Service (IHS) are eligible to use the Service Unit’s school-based behavioral health clinic.  **What services may be offered?**   * Behavioral Health Services   + Treatment for depression, anxiety, grief, substance abuse, attention problems, etc.   + Individual counseling   + Psychiatric medication management   + Telehealth services   **Who provides services?**   * Mental Health Specialist * Nurse Practitioner * Nursing Staff * Psychologist * Substance Use Therapist * Social Worker * Traditional Healer   **What does it cost?**  There is no charge to the student or family for services offered in the school-based behavioral health clinic. The Service Unit may bill third parties, including Medicaid and third-party insurance, without cost to families, where applicable. | **Parent/Guardian Involvement:**  A parent or guardian must sign a consent form before their student may use school-based behavioral health services. After appropriate consent, the student may use the services at any time and initiate their own visit during the consented period.  Supporting family communication is an important goal of school-based behavioral health clinics. Clinic staff encourage patients to discuss their care with their parents. Parents are not routinely notified when a student uses the clinic, except by student request or when staff become aware of serious concerns.  **Important Note**: Minors are allowed by law to seek access for certain confidential behavioral health services without parental consent or notification. This includes treatment of alcohol and substance abuse.  **Confidentiality**:  Medical information is protected by the Privacy Act, the Health Insurance Portability and Accountability Act (HIPAA), and other applicable federal laws. The Service Unit will only share such information in accordance with such laws. |

**Fort Thompson IHS School-Based Behavioral Health Clinic Consent Form**

**I hereby give my permission for my child to receive behavioral health services through the School-Based Behavioral Health Clinic. I understand that:**

* Services available through the clinic include Behavioral Health Services, including counseling and psychiatric medication management.
* The School-Based Behavioral Health Clinic is managed and operated by the Fort Thompson Service Unit – Indian Health Service.
* Care in the School-Based Clinic is confidential and protected by federal law, including the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA). Health information may only be shared between the clinic and school staff as permitted by federal law.
* In the event that patient is referred for behavioral health services via telehealth, I authorize use of video conference sessions. In the event that the behavioral health professionals feel that formal psychological testing is recommended and/or medications are needed, I understand that I will be notified prior to the initiation of treatment, testing, and/or medications.
* I will be notified of any serious problem requiring ongoing testing or treatment.
* I am encouraged to participate in my child’s care. While some types of adolescent health care may not require parental notification and/or consent, all teens are encouraged to involve parents in their care whenever possible.
* This permission is valid for current 2024-2025 school year, however, I may choose to withdraw consent at any time in writing to the school-based clinic.

Print Full Legal Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (if patient 18 years of age or older): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_