Coffee Club

Information and Registration Packet

January 9, 2018 – February 13, 2018

Tuesdays 4:00-5:00pm (ages12-14 year old girls)

Tuesdays 5:15-6:15pm (ages 15-19 year old girls and boys)

This collaborative, cross-disciplinary social group is developed and co-led by a speech language pathologist and a clinical social worker from the Children's Program. We are excited to offer this unique opportunity to support clients from a holistic, comprehensive framework that addresses both the social communication and social-emotional components of peer relationships.

Robin Goldberg, MA, CCC-SLP and Kayla Hoskins, M.S., CSWA

What is COFFEE CLUB?

This is an opportunity for teenagers with pragmatic language impairment, social anxiety, autism spectrum disorders, and/or related social and emotional challenges, to strengthen and expand social experiences in a less structured, more naturalistic setting. This group meets Tuesday afternoons (age 12-14) and evenings (age 15-19) at Starbucks in Raleigh Hills for delicious drinks and treats, while working on social communication and relationship skills, including: initiating conversation, joining/entering into a group conversation, assessing listeners' interests, sharing conversation control (reciprocity, talking about less preferred topics), social politeness ("using a "social fake"), and developing friendships. Clients will also have a supportive opportunity to practice important skills for independence, such as arriving on time, ordering food and drinks, and managing money.

Who is leading COFFEE CLUB?

We are so excited to offer this collaborative, cross-disciplinary series, which is developed and co-led by a speech language pathologist and a clinical social worker. By addressing social interactions from both a communication and emotional framework, we are best able to support our clients as they navigate individual barriers to social success, such as by targeting conversation skills, perspective-taking, social politeness, flexibility, friendship development, emotion regulation, and social anxiety.

Robin Goldberg, M.A., CCC-SLP, is an ASHA-certified speech language pathologist who received her Master's degree in Speech Language Pathology from The George Washington University in Washington, DC. Before relocating to Portland, Robin served as Chair of the Speech and Language Department at an independent school in New York City, where she worked with students with language-based learning disabilities, autism spectrum disorders, receptive-expressive language disorder, and social pragmatic difficulties. In this role, Robin spear-headed a school-wide speech-language/occupational group therapy curriculum, which targeted social communication, peer relationships, and conflict resolution in the classroom. In addition to her previous school position, Robin has extensive experience working at the outpatient level, where she provided comprehensive speech and language evaluations and individual and group therapy. She favors a naturalistic, client-centered approach largely influenced by a developmental and relationship-based model, and has participated in many training programs to support her work, such as The DIR-Floortime Method and The Social Thinking Curriculum by Michelle Garcia Winner.

Kayla Hoskins, M.S., CSWA, is an Honors program graduate from University of Oregon and earned her Masters of Science degree in Advanced Clinical Social Work Practice from Columbia University in New York City, specializing in Health, Mental Health, and Disabilities. Kayla has experience in school and various healthcare settings, and has worked extensively with children and families from diverse backgrounds. She enjoys helping each individual she works with to reach their full potential within their environment. Her current interests include early childhood, developmental and behavioral problems, and mindfulness. Kayla utilizes family-systems and cognitive behavioral strategies, and has experience and training in dialectical behavioral therapy, trauma focused cognitive behavioral therapy, collaborative problem solving, and acceptance and commitment therapy. She works with young children, providing individual and group therapy to address behavioral and emotional concerns.

FAQ's

What is the cost of the series?

The cost of this series is $300 for 6 weekly sessions (does not include the cost of meals). A short 30-minute interview is required for current clients, at no additional charge. New clients must schedule an initial consultation with one of the group leaders ($105).

What if we miss a group session?

The program is considered a "package" service. There is no credit for sessions that are missed. Given the social focus of this group, we strongly encourage participants to attend all sessions.

Do you bill insurance?

This group is not insurance billable.

Where and when do we meet each week?

The group will meet at a neighborhood Starbucks, located within 10 minutes of the Children's Program (6443 SW Beaverton-Hillsdale Hwy, Portland, OR, 97221). Drop-off/pick-up is at Starbucks, not the Children's Program, at the start and end times of the session.

What if I have food allergies? The group leaders cannot assume responsibility for individual food allergies. It is the responsibility of each client to indicate her food allergies and to select foods within her diet. Please speak with us directly, before the group series begins, if your teen has any serious, life-threatening food allergies, so that we can support her properly.

What about confidentiality at the coffee shop? We will try our best to choose seating in a quieter section of the coffee shop, in order to provide as much privacy as possible during sessions. However, given the community-based nature of this group, we cannot guarantee the level of confidentiality available in a private clinic setting.

Class Registration Form

☐ **Spring** ☐ **Fall** ☐ **Winter**

Child's Name: _____ DOB:_____ _____

Address: _____

Parent / Guardian Name: _____

Phone Numbers: Day _____ Cell_____ Evening: _____

E-mail _____

Has your child been seen at this clinic before? ☐ Yes ☐ No
If yes, for: ☐ evaluation ☐ therapy ☐ other groups

Group/Class Name ___Coffee Club_____

Dates/Times (Select time below**): January 9, 2018 – February 13, 2018**

____ Tuesdays 4:00-5:00pm (ages12-14 year old girls)

____ Tuesdays 5:15-6:15pm (ages 15-19 year old girls and boys)

THIS CLASS REQUIRES PAYMENT IN FULL UPON REGISTRATION. If you must cancel, please notify us within **4** business days prior to the start of the class so we can refund your registration fee. Cancellations received after that time will receive a refund, less a $35 administrative fee. We reserve the right to refund your registration by check. Your refund will be mailed to you within approximately four weeks.

☐ **Check (please mail)** ☐ **Mastercard** ☐ **Visa** ☐ **Discover** ☐ **AMX** ☐ **PayPal**

(Provide credit card information below)

Cardholder's Name: _____

Card Number: _____ Exp. Date: _____

Security Code: _____

Return this form by mail or fax to the Children's Program along with your completed registration packet.

6443 SW Beaverton-Hillsdale Hwy, Suite 300, Portland, OR 97221
Fax to (503) 452-0084

TREATMENT CONSENT

WELCOME TO THE CHILDREN'S PROGRAM! We look forward to assisting you with your goals. Here is some important information you should know BEFORE we begin to work with you/your child(ren)/family.

STAFF AND OUR SERVICES: The Children's Program is a private, multidisciplinary clinic. Our clinical staff consists of a licensed developmental/behavioral pediatrician, consulting psychiatrists, licensed psychologists, licensed professional counselors, and certified educational specialists. We help adults, families and children with social, emotional, developmental, and learning concerns. When you call for an initial appointment we encourage you to formulate questions for us to answer or specific goals you want to accomplish. With that information we will schedule appointments for consultation, evaluation and/or treatment with appropriate staff. We will attempt to remind you of your appointment via email, text and telephone.

During the first appointment, your clinician will introduce him/herself to you and, at your request, share specifics regarding his/her education and training. You can then further clarify goals and agree how they will be reached. If you have difficulty describing clear goals for treatment, it is important to discuss this with your clinician. We will work with you to meet your/your family's specific needs. It is a collaborative process that is provided without a guarantee of satisfaction or results. You retain the right to request changes in treatment or to end treatment at any time. When medication is recommended, your doctor will discuss the risks, benefits, and alternatives. When accepting a prescription for medication, you agree to follow the prescribing physician's recommendations regarding ALL aspects of treatment. If we recommend referral inside the clinic, information will be shared between clinicians. If we recommend referral outside our clinic, we will attempt to provide you with alternatives.

IF YOU ARE RECEIVING SERVICES UNDER A MANAGED CARE HEALTH INSURANCE CONTRACT, your policy may limit behavioral health coverage to **"medically necessary" procedures (for acute symptom relief)**. It is the responsibility of the patient/ family to ensure all necessary preauthorization is current. Your provider has an agreement with your insurance company to provide services within the limitations of these conditions. The managed care company may require a release of information about your treatment to the primary care physician. Your managed care health insurance company hires reviewers to assess the record keeping and functioning of provider offices. As part of this process, they may either send a reviewer to our office to inspect your record or request a copy of your record be sent to their office for review. If this is the case, we will follow all procedures to protect the confidentiality of your record. Your managed care insurance may request that information regarding treatment and/or treatment authorization be transmitted via facsimile or e-mail. If you do not want us to send or receive information in this manner on your behalf please inform your clinician and specify this request in writing. Some concerns you want to address in therapy may not meet the conditions of your insurance coverage. Should you want to receive treatment for a non-covered condition, your therapist will discuss options with you.

The Children's Program will not be a party to any legal proceedings/lawsuits. Our goal is to support clients to achieve therapy goals, not to address legal issues. Clients entering treatment agree not to involve the Children's Program and their treating clinician in legal/court proceedings or attempts to obtain records of treatment/evaluation for use in legal/court proceedings.

CONFIDENTIALITY: The privacy of your evaluation/treatment is important to us. Information shared with clinicians is confidential. The Children's Program maintains a single chart to record the services that are provided. We will maintain your chart for 7 years from the last date of treatment. Information from that record can be shared with other professionals/agencies/individuals **ONLY** with your **WRITTEN** consent by signing a release to disclose confidential information. Please be conservative and circumspect when requesting release of information. This is to protect your child/family's privacy now and into the future as your child ages. Please be aware that the record we release may be released by other providers/agencies. The Release to Disclose Confidential Information form requires specifying **WHAT** information is to be shared, **WHO** shall receive it, for **WHAT** purpose and the **DATES** of the confidential information. In Oregon, the age of consent for treatment and release of mental health records is 14 years of age. The signature of patients 14 years or older is required to release the information in the treatment record. With written permission, we can communicate with other professionals on your behalf via phone or email and provide evaluation reports and/or a summary of treatment. We do not generally release patient chart notes or test protocols. If under a special circumstance, release of additional information is requested, this will be reviewed after conferring with the patient/family members and the requesting clinician/physician. There may be charges for photocopying and mailing records. In the case of divorce, both parents have equal access to the information in the chart of a child under the age of 14. If consultation with other professionals on your behalf is necessary, your anonymity will be preserved.

We may, but do not guarantee calls to remind you of upcoming appointments. Please let us know **EACH** time you schedule an appointment if you **DO NOT** want a reminder call.

We respect the rights of a child/parent/adult to have particular information remain private between themselves and the therapist. If you have concerns about this, let your therapist know and a comfortable arrangement can be reached which allows therapy to progress, yet respects the rights of individuals. Please advise us in writing if you wish to be contacted only in a particular way or only at particular phone numbers. There are several situations in which the law requires clinicians to make exceptions to the confidentiality of communications between client and clinician. These situations are:

- when there is suspected child, elder, or disabled abuse
- when there is threat of harm to self or others
- when medically relevant information is needed for emergency medical treatment
- when records are subpoenaed by order of a Judge, or if the client waives confidentiality
- when conducted at the request of an outside agency with the client's approval

(please see reverse side)

information may be required by your insurance company to process a claim. Typically, this involves disclosure of a diagnosis and the dates of services, though at times, more may be required. Your file may be reviewed for quality assurance by the Children's Program or your insurance company. We will maintain your confidentiality during this process.

ELECTRONIC COMMUNICATION, I.E., E-MAIL/FAX, PRESENTS A POTENTIAL RISK TO PATIENT CONFIDENTIALITY. Email is not a replacement for office visits. While families and patients may find this a convenient way to communicate they must be aware of the risks and discuss them with their clinician. If a patient/family still wishes to assume these risks and communicate with their clinician in this way, they may acknowledge this by signing below and exchanging information with their clinician within a session. Clinically relevant information exchanged by fax/email may become a part of the clinical record.

FEES/PAYMENT: Fees are billed on an hourly basis and vary for each discipline. When you call for an appointment, we provide an estimate of the fee(s). We will inform you if this changes. We request payment of the fee(s) at each appointment. In some cases, we will bill your primary insurance directly. HOWEVER, THIS DOES NOT GUARANTEE COVERAGE. Health insurance plans vary widely in their mental health coverage. A copy of our **FINANCIAL POLICY** is available on our website. **Please read our Financial Policy**. We require that you read/sign **INFORMATION** and **CONSENT FOR PAYMENT** forms prior to initiating evaluation/treatment**.** We require you provide a valid credit card number. Charges remaining after 90 days may be charged if you have not called us regarding arrangements for payment of a past due balance

There are circumstances that impose additional fees. To cancel a scheduled therapy or consultation appointment, please call during office hours and give at least 24 business hours' advance notice. A mandatory fee of up to 100% of the charge will be assessed for missed appointments or appointments cancelled without sufficient notice. Cancellations left on voicemail after business hours will be considered received as of the next business day. Reminder phone calls are not guaranteed. If you must cancel an evaluation appointment, please notify us at least one week in advance. We may elect not to reschedule evaluations cancelled without sufficient notice. You will be charged for telephone/email consultation outside a session or a cancellation without sufficient notice. This is billed at the clinician's hourly rate and is not reimbursable by a health insurance company. Same day requests for refills of prescriptions incur a $10 charge. If a clinician is required to testify on a client's behalf court preparation/travel/testimony will be billed at $200 per hour. In the unlikely event that your account is referred to a collection agency or small claims court, we will release your name, address, phone number, social security number, and amount owed. You will be notified in writing if this is to occur.

EMERGENCIES: Office phones are answered between 8:00 a.m. and Noon and 1:00-5:15 p.m. Monday through Thursdays and between 8:00 a.m. – Noon and 1:00-3:30 p.m. on Fridays. The office is closed on Fridays during July and August. Messages may be left on the voicemail at any time. Our clinicians will attempt to return your call within 24 hours. If you feel you have an **emergency** situation that cannot wait until the office re-opens, please call the Answering Service at (503) 294-1309. They will make every effort to contact your clinician; however, it is possible that your clinician may be unavailable or unreachable. Families needing immediate attention are advised to contact the Emergency Room of the nearest hospital.

GRIEVANCE PROCEDURE: If you have concerns regarding these policies, please discuss them with your clinician during your initial session. Should you feel dissatisfied with your treatment for any reason, please talk to your clinician. If you and your clinician are unable to resolve the problems, you may submit a written letter of concern to our Clinic Administrator. You will receive notice of action taken within 10 working days.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND I CONSENT TO TREATMENT. BY FURNISHING MY EMAIL ADDRESS, I CONSENT TO THE USE OF EMAIL TO COMMUNICATE.

Email Address: _____

_____

Name of Patient (Date of Birth)

_____

Signature (clients age 14 years and above) (Date)

_____

Signature (Parent/Guardian/Legal Rep.) (Relationship to Client) (Date)
(If Guardian/Legal representative, please provide documentation of guardianship status.)

_____

Clinician's Signature (Date)

Please sign and return this form.

6443 SW Beaverton Hillsdale Hwy, Suite 320, Portland, OR 97221
(503) 452-8002 Fax: (503) 452-0084
www.childrensprogram.com

REGISTRATION CHECKLIST

GIRLS' DINNER OUT GROUP

Did You:

1. Complete the **Registration** form. **Payment in full must accompany the registration.**

2. Remember to put all the meetings on your calendar!

3. Read, sign, and return the Consent for Payment and Health Care Operations form. Your credit card numbers MUST be included for your registration to be processed unless you are paying in full.

4. Read, sign, and return the Treatment Consent form.

Keep this packet handy while your child is attending the group program. You may want to refer to it in the future.

Children's Program
(503) 452-8002