CARE SOLACE REFERRAL SERVICE CONSENT FORM

TO THE PARENT(S) OF _____
Student Name

Care Solace is a complimentary and confidential service provided to students, staff, and their families by Bartlesville Public Schools. Care Solace can connect families with providers that help with mental health or substance use. It has providers accepting all medical insurances, including Medicaid, Medicare, and sliding scale options for those without insurance. Care Solace is NOT an emergency response service nor it is a mental health services provider.

Care Solace needs the following information to assist a student:

- Basic contact information for the student and guardian
- Insurance provider and plan
- Brief description of what the student is experiencing
- Type of service desired

Services that Care Solace include help with anxiety, depression, disruptive, suicidal ideation and self-harm, ADHD, bipolar, couple/family counseling, feeding & eating, obsessive compulsive, trauma & stress, and addictive behaviors involving alcohol, cannabis, hallucinogens, inhalants, opiods, sedatives or hypnotics, and stimulants.

- NOTE: Self-referrals can be made at **caresolace.com/bps** or by calling 888-515-0595.

☐ **I authorize the school district to release basic contact information about my child and his or her guardian(s), insurance provider and plan, a brief description of what the student is experiencing, and the type of service desired. I understand that information on individual treatment providers is gathered by Care Solace based on criteria such as geographic proximity, whether the provider accepts the authorized user's insurance, and whether the provider is accepting new patients. I understand that the school district does NOT recommend, endorse, promote, or refer to any of the individual treatment options.**

_____ _____
Parent/Guardian Signature **Date**

FOR STUDENTS AGE 18 OR OLDER:

☐ **I attest that I am at least 18 years of age and authorize the school district to release basic contact information about me, insurance provider and plan, a brief description of what I am experiencing, and the type of service desired. I understand that information on individual treatment providers is gathered by Care Solace based on criteria such as geographic proximity, whether the provider accepts the authorized user's insurance, and whether the provider is accepting new patients. I understand that the school district does NOT recommend, endorse, promote, or refer to any of the individual treatment options.**

_____ _____
Student Signature ***(only valid if at least 18 years old)*** **Date**