CONSENT TO TREATMENT FOR A MINOR

As the parent/guardian of a minor who is participating in Services:

I acknowledge that I have received, have read (or have had read to me) and understand the "Family Health Care Behavioral Health Program Orientation" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent for my child to take part in outpatient counseling at the Family Health Care program. I understand that participating in an initial evaluation, developing a treatment plan, and regularly reviewing the work toward meeting the treatment goals are in my child's best interest. As a parent/guardian, I agree to play an active role in this process, as requested by the counselor.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by the assigned therapist/program. I am aware that my child may stop treatment with the assigned therapist at any time. The only thing I will still be responsible for is paying for the services already received. I understand that I/my child may lose other services or may have to deal with other problems if it is decided to stop treatment. (For example, if the treatment has been court-ordered, we may have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I may be discharged from treatment due to non-participation.

I understand that Federal laws and regulations protect my health information to that extent afforded by the laws (See 42, U/S.S 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations.) Exceptions to this law or instances when your information may be released include:

- Written consent by the client/parent/guardian
- Internal communications within the agency, as necessary
- Medical emergencies
- Court order
- Crime at program/against program personnel
- Duty to warn and protect when patient is suicidal or homicidal
- Research with no client-identifying information
- Audit and evaluation by external agency/entity as required for licensure/accreditation
- Suspicion of abuse and/or neglect against a child or vulnerable adult
- A qualified service organization/business associate agreement
- Insurance company or 3rd party payer for billing purposes

My signature below shows that I understand and agree with all of these statements.

Signature of parent/guardian of minor _____ Date _____

Printed name _____ Relationship to client (if necessary) _____

Patient name _____

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative).
My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist _____ Date _____

☐ Copy accepted by client ☐ Copy declined by client ☐ Copy kept by therapist

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.