ADVANCED BEHAVIORAL MEDICINE, PC

# Child Consent to Treatment

Patient Name: _____

You are agreeing to treatment at our clinic, Advanced Behavioral Medicine PC ('ABM') according to the following agreement and guidelines.

## Patients Rights:

- You have the right to receive necessary care regardless of your race, sex, national origin, marital status, sexual orientation, beliefs, values, language, functional, age, disability or source of payment.
- You have the right to receive considerate and respectful care in a smoke-free environment.
- You have the right to privacy, to receive information about rules involving your care or conduct, and to be free from mental or physical abuse or harassment.
- Individuals age 14 and older have, in many circumstances, the right under Michigan law to consent to receive treatment on their own without a parent's knowledge or approval, within certain limitations. If a minor child has the legally right to consent to treatment, that child may also have some rights to restrict even parents from access to his or her medical information.
- You have the right to information about your condition, treatment, including safe use of medications, and prognosis, including unanticipated outcomes of care.
- You have the right to know who is taking care of you and his/her professional titles.
- You have the right to be involved in the planning, completion and review of your plan of care.
- You may refuse treatment to the extent permitted by law. It is our responsibility to discuss with you the possible results of your refusal.
- You have the right to participate in health care decisions and we will try to understand and respect your requests as long as they are medically appropriate and within our reasonable capability.
- No experimental procedure can be a part of your care without your approval.
- Your right to make decisions about health care does not mean that you can demand treatment and services that are medically inappropriate or unnecessary.
- You have the right to have health care information provided in a manner and form that you can understand.
- You have the right to details about all items on your bill. You will receive notice of non-coverage. Upon request information concerning financial help will be given to you.
- You have the right to express any concerns you may have regarding your care. We encourage you to communicate concerns or compliments to the individual involved, or to Recipient Rights Officer, Evelyn Dionise, or the Clinic Director, Dr. Matossian, both at (517)548-1537.
- You have the right to file a formal written or verbal grievance with clinic office if we can not promptly resolve your concerns.
- You also have the right to lodge a grievance with the State of Michigan Department of Consumer & Industry Services, Bureau of Health Services, PO Box 30670, Lansing, MI 48909-8170, (517) 373-9196.

## You are responsible for:

- Following the rules involving patient care and conduct.
- Identifying the problems you want help with and to work with the clinicians on a treatment plan.
- Providing a complete and accurate medical history, including all prescribed and over-the-counter medications that you are taking, all recreational drugs or alcohol use and all treatments and interventions that you are involved in.
- Following the suggestions and advice prescribed in a course of treatment by your health care providers, or accepting responsibility for the consequences of failing to do so. If your refusal of treatment prevents us from providing care according to ethical and professional standards, we may need to end our relationship with you after giving you reasonable notice.
- You are responsible for being considerate of the rights of other patients and ABM personnel.
- Providing information about unexpected difficulties you have involving your health care, and making it known whether you clearly understand your plan of care and the things you are asked to do.
- Making appointments, arriving on time, and paying for appointments missed, rescheduled or cancelled less than one business day in advance of the appointment time.
- Knowing your insurance benefits and co-pays, getting pre-approval when necessary, and paying for any balance remaining after insurance adjustment, regardless of our prior estimates of your co-pay amount.

**PATIENT NAME** _____

- Providing us with correct information about your sources of payments and ability to pay your bill, and paying for charges not covered by insurance

## Patient Consent:

By signing below, I agree to accept services from Advanced Behavioral Medicine, PC. I received a copy of the HIPAA Privacy Notice. I agree that my confidential information may be released to my insurance carrier, my doctor, and to others, as described in the HIPAA Privacy notice.

**I agree to keep all scheduled appointments or provide advance notice of cancellations, whenever possible. I agree to pay a $50.00 fee for appointments missed, rescheduled or cancelled without 24 hour notice the first time and the full clinic rate following, regardless of reason.** I agree to pay an interest charge of 1.4% per month on any unpaid balance after 30 days.

I have been given and read the information rate sheet and you understand that fees are subject to change. I understand that ABM policies described above may change over time and if so the changes will be posted in the clinic lobby or distributed to me directly.

**I agree** _☑_ or **do not agree** _☐_ to allow my ABM to share, for the purpose of coordinating care, my evaluation and treatment information with my current physician or other medical professional involved in my care, listed below. This permission to share information will expire 12 months from today.

**Current physician or other medical/mental health provider**:

_____

_____

**I agree** _☐_ or **do not agree** _☐_ to allow ABM to survey me during or after treatment about the quality of the care I received. I understand that I may ignore the survey or choose not to participate.

If the patient is enrolled in school, **I further agree** _☐_ or **do not agree** _☐_ to allow ABM personnel to ask questions, send questionnaires, and receive records from professional staff at my/my child's school, listed below, for the next 6 months from the date this form is signed for the purpose of determining my/my child's medical diagnosis and educational needs.

**Teacher/Counselor Name**: _____

**School Name & Address**: _____

_____

I have understood and agreed to all the rights and responsibilities described above. I am voluntarily seeking services, including medical assessment and treatment, at Advanced Behavioral Medicine, PC. If I am found to have a medical illness I will be offered usual and customary treatment or be advised to the contrary. I understand that this process begins with an initial assessment and may include recommendations for psychological testing, psychiatric evaluation, prescription medication, individual psychotherapy, family or group psychotherapy, and other prescribed treatments.

**Parent, Guardian, or Legal Representative:**

I have legal custody or other authority of the patient, who is a minor child. I agree to all of the above on behalf of the patient, and I accept financial responsibility to reimburse ABM for any fees owed on behalf of the patient and not paid within sixty days. Parent, guardian or representative consent required on behalf of patient if patient is under 18 years of age, not competent to make healthcare decisions, or incapable of providing consent.

**Parent/Guardian Name:** _____

**Parent/Guardian Signature:** _____

**Relationship:** _____

**Date:** _____

**If 14 years or older Patient Signature:** _____

**Date:** _____

**Optional** *PARENT* **Email:** _____