Consent for Treatment

I have come to Second Chance Counseling Center for evaluation, treatment and/or referral. I understand that these services may be provided by a Social Worker and licensed in the State of Michigan. Furthermore, I understand that Second Chance Counseling Center provides a ***Person-Centered Approach & Planning*** in that I am an active participant in my goals and treatment.

_____I am aware that some people may not benefit from mental health services. I acknowledge that no guarantees have been made to me as a result of services and treatment provided by Second Chance Counseling Center.

_____I am aware that, depending on the requirements of my ***insurer or referral source***, information about the services I receive may be accessible by phone, in written form or in a computerized information system at times by providers of other services I am authorized to receive.

_____I understand that I may ask questions about the risks and benefits of any treatment, procedures or any other therapeutic processes that relate to me. I understand that my consent for treatment is freely given and I may discontinue treatment at any time, but there may be risks involved and I will discuss it with my therapist or doctor.

_____I understand that the **Michigan Mental Health Code, Act 258 of 1974, 330.1707 Rights of Minor,** allows for minors who are 14 years and above to seek treatment without parental disclosure for 12 sessions or 4 months.

I understand that by signing this ***Consent for Treatment*** I grant permission for the exchange of information with my ***Primary Care Physician and Insurance Provider***. Furthermore, I give Second Chance Counseling Center permission to bill my insurance company ____________________________ for services rendered.

______I have been made aware of Second Chance Counseling Center LLC's policy and procedures during the orientation process.

______I have received a Complaint's procedure statement and a Complaint Form for Second Chance Counseling Center, LLC.

Second Chance Counseling Center LLC uses text and email to communicate regularly with clients for appointments, personal health information (PHI), face-to-face consultation, telehealth therapy services and important documents needing signatures.

☐ I **do give** permission for my therapist to communicate with me for the reasons listed

☐ Email ☐ Text ☐ Release of PHI ☐ Face-to-Face Consultation ☐ Document Signatures

☐ I **do not give** permission for my therapist to communicate with me for the reasons listed above.

_____I understand that I have certain rights as a recipient of services with Second Chance Counseling Center, including the right to a second opinion if I disagree with treatment recommendations that result from my clinical evaluation.

______I have received a ***LARA Know Your Rights Brochure***.

Information may be released to the proper authorities if it is necessary to keep myself or others from being harmed. This includes abuse, neglect, exploitation and endangerment.

Signature: ____ Date: __________________________

Client/Legal Guardian or Parent of Minor