Alcona health center "Your family health center"
Alcona Community Schools
A PARTNERSHIP IN BEHAVIORAL HEALTH

BEHAVIORAL HEALTH TREATMENT CONSENT FORM

Alcona Health Centers (AHC) is offering behavioral health services (BHS) at Alcona Middle/High School. These services will be provided by Trudi Marsh, LMSW, a State of Michigan licensed clinical social worker employed by Alcona Community Schools and in partnership with AHC as a behavioral health therapist. As a condition for offering these services to your child, AHC is requiring that a parent or legal guardian must give written, informed consent, as outlined below. This consent may be revoked at any time.

As the parent or legal guardian of _____(name of child@ Alcona Middle/High School):

1. I understand that BHS will include a behavioral health assessment of my child, during which I may be asked to provide information about my child's emotional needs and behavior at home and school. I may be invited to be actively involved in the treatment planning for my child. My acceptance of counseling services for my child is on a voluntary basis, and I may terminate these services at any time.
2. I understand that Trudi Marsh, LMSW maintains professional liability coverage and follows federal and state laws protecting client's rights to confidentiality of personal information. I understand these laws allow the exchange of Protected Health Information with other medical personnel involved in the treatment of my child. I have the right to be informed of these exchanges of information and may request more information about privacy laws, including HIPPA by writing to the Office of Civil Rights, Secretary of the U.S. Department of Health and Human Services.
3. I understand that Trudi Marsh, LMSW may exchange information with the school staff and have access to my child's school file, as needed for treatment and care my child.
4. I understand that counseling is a fee for service agreement and that my insurance company will be billed for services. I further understand that I will be responsible for any portions of fees and/or additional fees not covered by my insurance provider. AHC encourages parents/guardians to contact their child's insurance company directly so you are informed about Behavioral Health services coverage for your child. It is a parent/guardian responsibility to know your insurance benefits. Alcona Health Center will not be contacting your insurance company directly to inquire about Behavioral Health services coverage in order to begin services with your child.
5. I understand that federal and state regulations protect the confidentiality of my child's records maintained by this program, except when the following conditions exist:
   a. There is suspected evidence of child abuse, neglect, or danger to my child; or
   b. The Michigan Department of Health and Human Services, Child Protective Services requests Behavioral Health information by directly submitting the DHS-1163-P form to Alcona Health Center and/or this Behavioral Health Therapist; or
   c. A medical emergency requires disclosure to medical personnel; or
   d. The likelihood of alcohol or drug abuse, and
   e. My written permission is given to release this information, as you deem appropriate in good faith, to specific agencies or persons who are from time to time, authorized by law to receive such information.

I HAVE READ AND UNDERSTAND THE CONDITIONS OUTLINED ABOVE, AND BY SIGNING BELOW AUTHORIZE TRUDI MARSH, LMSW TO OFFER BEHAVIORAL HEALTH SERVICES TO MY CHILD.

_____ _____
Signature of Parent(s) or Legal Guardian Signature of Witness

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Date: ____/_____/_____ Date: ____/_____/_____