Therapist Disclosure Statement,
Adolescent Patient Informed Consent,
Without Parent/Guardian Consent

Michigan State Law recognizes the right of a minor child, 14 years of age or older to ask for and receive outpatient mental health services (not including psychotropic medication) without the consent or knowledge of a parent/guardian. Patients can access counseling up to 12 visits, or 4 months for each separate request. There are some special considerations which exist that all patients need to be aware of;

- If you are a voluntary recipient of mental health services and you do not agree with some part of your treatment, you have the right to withdraw your consent to treatment at any time. If there is not another appropriate treatment to which you do consent, you may be referred appropriately to other services.
- You have the right to be told why you are being treated, what your treatment is, and how much you will be charged for your treatment.
- You have the right to participate in the development of your treatment plan and to involve family members, friends, advocates and professionals of your choice in the development process.
- You have the right to be informed of your progress in treatment, both orally in sessions and in writing, at reasonable intervals and in a manner appropriate to your condition.
- You have the right to see your record. Upon your request, you or your legal representative may read or get a copy of all or part of your record. There may be a charge for the cost of copying. If you believe your record contains incorrect information, you or they may place a statement in your record which corrects that information. You may not remove what is already in the record.
- You have the right to feel safe at all times. You will not be physically, sexually or otherwise abused while in treatment at Alcona Health Center.
- You have the right to have your mental health treatment kept private. Information about you and your treatment cannot be given to anyone except as required or allowed by law. Listed here are situations when confidential information may be released:
    - ✔ If a law or court order requires your records be released.
    - ✔ If you, or your legal representative, consent
    - ✔ If needed to get benefits for you or to get reimbursement for cost of treatment
    - ✔ If it is needed for research or statistical purposes, with certain safeguards regarding identification
    - ✔ If you die and your surviving spouse or other close relative needs the information to apply for and receive benefits

- ✔ If you tell your therapist/BHC that you are going to harm another person, he/she may have to notify the police and the person you threaten to harm
- ✔ If you report you or someone else has been abused or neglected in some way, your therapist may have to report this to the proper authorities to keep you or others safe

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I consent to therapy at Alcona Health Center.

Your signature below indicates that you have read the Disclosure Statement and Consent for Therapy document carefully and understand all of its contents. **Please ask your Behavioral Health Therapist (BHT) to address any questions or concerns that you have regarding the information contained in this document before you sign.** By signing this document, you agree that you have had all of your questions answered, 100%, and are agreeing to the outlined procedures and courses of actions necessary to engage in a patient-therapist/BHT relationship.

____ _____/______/_______

Signature of Patient 14 yrs. and older Date

____ ____/______/________

Trudi Marsh, LMSW Date

Behavioral Health Therapist