YOUTH HAVEN BEHAVIORAL HEALTH
CONSENT FOR TREATMENT

The following information is to be completed by the client, or the client's legally authorized representative/parent:

I consent to medical and behavioral health treatment for myself or for the child for whom I am the parent or legally authorized representative.

- ♦ I understand that Youth Haven will share protected health information (PHI) according to federal and state law for treatment, payment, and operations.
- ♦ I understand that my right to privacy is protected by Federal and State laws and that I am the holder of privilege within the client/therapist setting.
- ♦ I understand that this means that information discussed during treatment at Youth Haven is confidential and that no information can be released to anyone outside Youth Haven without written authorization from me, with certain exceptions, as outlined below.
- ♦ I understand that there are several exceptions to the client/therapist privilege. For example, under Florida Law Youth Haven Behavioral Health must report:
  - a. child abuse
  - b. elder abuse
  - c. abuse of mentally ill persons or developmentally disabled persons
  - d. when required by a court order
  - e. harm or potential harm to self or others

I understand that in cases of medical emergency, information sufficient to resolve the situation may be disclosed to emergency personnel, and I will be informed of this disclosure as soon as feasible.

I understand that if I have a Medicaid card, by signing this agreement, I am authorizing that sufficient information be exchanged between any Medicaid Providers involved in my past or present treatment to manage my Medicaid benefits, assure utilization review, and facilitate quality assurance and coordination of treatment.

I understand that if I have insurance, my insurance company may request information regarding diagnosis and treatment, and that by signing the insurance form I will be authorizing this release of information.

I understand that adolescents age 14 or older have the right to request mental health and substance abuse treatment and confidentiality; and that confidentiality may be an important issue for youth under the age of 14. I understand that it may be necessary to establish an agreement between parents/guardians and youth which clearly defines agreed upon limits of confidentiality. In any event, I understand that Youth Haven clinicians reserve the right to make clinical decisions regarding such confidentiality issues between adolescents and parents/guardians.

I understand that the client is responsible for all charges incurred, regardless of the client's insurance status. I understand that I will be billed on a sliding fee scale for services should I have no insurance or Medicaid Card. I authorize the insurance provider to pay Youth Haven for services rendered.

I understand that my participation in treatment is voluntary, and that I may withdraw from treatment at any time.

Signature of Client: ____ Date: __________

Signature of Parent/Guardian: ___________________________________ Date: ___________

Signature of YH Staff: ____ Date: ___________

JAH8/2010