Treatment Consent

This document describes the nature of the agreement for professional services, the agreed upon limits of those services, and rights and protections afforded under the American Counseling Association's Guidelines for Responsible Conduct of Certified Counselors. I will receive a copy of this document to retain for my records.

I, ________________________, agree to have my child, ________________________ participate in Mental Health Evaluation and treatment services provided by Superior Behavioral Services. I understand that the specific activities, goals, and desired outcomes of these services will be fully discussed with me, and that I will have the opportunity to ask for clarification prior to signing this document. I also understand that I have the right to ask follow-up questions throughout the course of service delivery to ensure my full participation. My insurer also has rights regarding the services that are being provided and all services and types of services may be subject to approval from my insurer. I also understand that my child is the primary client of the therapist and that services will be designed primarily for my child's benefit. Any other individuals or agencies (e.g., siblings, family, day-care providers) who may be affected by the services are considered secondary clients.

Right of refusal. I reserve the right to withdraw at any time from these services and I understand that such a withdrawal will not affect my child's right to services. In addition, I reserve the right to refuse, at any time, the treatment that is being offered.

Confidentiality. I understand that the procedures and outcomes of all assessment and treatment services are strictly confidential and will be released only to agencies or individuals specifically designated by me in writing. In addition, the fact that my child receives any services is protected and private information. I am aware that Superior Behavioral Services may release information without my prior consent if so ordered by a court of law. I am also aware that providers are legally required to report suspected occurrences of child abuse or neglect or if I or my child present clear and present danger to ourselves or to others. I understand that my child's assessment and treatment services may be observed by supervisors or other employees as part of ongoing training and quality assurance activities.

Authorization to bill insurance. I authorize Superior Behavioral Services to submit claims on my behalf and to release any medical or other information necessary to process my claims.

These policies have been fully explained to me, and I fully and freely give my consent and permission for my dependent.

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Parent/Guardian (Print)

____ Date ____________________

Parent/Guardian (Signature)