BODY-BASED PSYCHOTHERAPY OF METRO DETROIT, PLLC

NAME:____DATE OF BIRTH:__________________

CONSENT TO TREATMENT AND CLINICAL SERVICES

I understand that the treatment/services my dependent or I receive will be based on currently accepted practice in the fields of mental health and/or substance abuse treatment. I also understand that the outcome of treatment cannot be guaranteed and that services continue only with my voluntary consent.

I understand that my records or the records of my dependent are confidential. These records can be released only as allowed by law under statutes of the State of Michigan and Federal guidelines, or by my signature specifying the release of information to a specific individual or agency.

I understand if my dependent or I threaten to harm ourselves or someone else that State of Michigan statute obligates mental health professionals to take whatever action is necessary to protect people from harm. This may include divulging confidential information to others. Such action would be taken when someone's life appears to be in danger.

I understand if my dependent or I are involved in litigation of any kind and the court is informed of mental health/substance abuse treatment, I may be waving the right to keep records confidential. I further understand I may want to consult with my attorney before disclosing to a court that my dependent or I are receiving treatment or diagnostic services.

I understand if my dependent or I have been ordered by the court to seek treatment or diagnostic services, the court will require one or more reports. My written consent to release information to the court will be requested. I also understand that any report regarding my dependent or myself will not be released until my account is paid in full.

I understand it may be necessary to reach me by mail or telephone during or after me or my dependent's treatment for the purpose of scheduling or confirming appointments, billing or payment issues, completion of forms, conducting surveys, and any necessary follow-up.

I understand that State of Michigan and Federal laws and regulations do not protect any information about suspected child and elder abuse or neglect from being reported to the appropriate state or local authorities.

I acknowledge that I am voluntarily authorizing diagnostic and/or treatment services for my dependent or myself. I acknowledge I may refuse any aspect of treatment, understanding that such a refusal could, in some instances, result in termination of treatment and/or services.

I have read this consent, received a copy of Body-based Psychotherapy of Metro Detroit, PLLC privacy practices and agree to comply with the policies and procedures.

____ __________
Patient/Parent/Guardian Signature Date

____
Witness Date