BEHAVIORAL HEALTH TREATMENT CONSENT FORM

Alcona Health Center (AHC) is offering behavioral health services (BHS) at **ALPENA HIGH HEALTH CENTER**. These services will be provided by Peggy Krajniak LPC, a State of Michigan Licensed Professional Counselor, employed by Alcona Health Center. 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 _____ DOB: _____

1. I understand Behavioral Health Services 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 Peggy Krajniak LPC 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 others only when the parent/guardian signs a release of information naming a specific person(s) or entity with whom the information is to be exchanged.
3. 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. You may be eligible for AHC's Sliding Fee program and/or a program which offers a payment plan. Ask your therapist for details. Services will not be denied based on the inability to pay.
5. I understand that AHC has taken steps to minimize exposure to COVID-19 in all school locations based on CDC guidelines. I understand that if my child appears in poor health, I may be contacted to reschedule their appointment until symptoms are evaluated by a medical professional. If I have any concerns regarding COVID-19, I will contact my child's therapist prior to their scheduled appointment.
6. 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 that may require a referral to medical personnel or
    d. "Duty to Warn (homicide threat/injury to another person) or Duty to Protect (suicide threat/injury to oneself)" or,

I HAVE READ AND UNDERSTAND THE CONDITIONS OUTLINED ABOVE, AND BY SIGNING BELOW AUTHORIZE Peggy Krajniak LPC TO OFFER BEHAVIORAL HEALTH SERVICES TO MY CHILD. I acknowledge this consent will remain active until rescinded or the student reaches age 18.

_____ _____
Signature of Parent(s) or Legal Guardian Signature of Witness
Date: ____/_____/_____ Date: ____/_____/_____

_____ My initials indicate that I have been offered a copy of AHC's Notice of Privacy Practices. https://www.alconahealthcenters.org/patient-privacy/