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# BEHAVIORAL HEALTH TREATMENT CONSENT FORM

Alcona Health Center (AHC) – Owl Health Extension Clinic is offering behavioral health services (BHS) at **RICHARDSON ELEMENTARY SCHOOL**. These services will be provided by Catherine Nickell-Simpson, LLMSW a State of Michigan limited licensed Master Social Worker employed by AHC as a behavioral health therapist. 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 that BHS 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 Catherine Nickell-Simpson, LLMSW 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 other medical personnel involved in the treatment of my child. I have the right to be informed of these exchanges of information and may request more information about privacy laws, including HIPPA by writing to the Office of Civil Rights, Secretary of the U.S. Department of Health and Human Services.
3. I understand that Catherine Nickell-Simpson, LLMSW may exchange information with the school staff and have access to my child's school file, as needed for treatment and care my child.
4. 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. Ask your therapist for details.
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 or public health concern, ie: COVID-19, requires disclosure to medical personnel; or
    d. "Duty to Warn(homicide threat/injury to another person) or Duty to Protect (suicide threat/injury to oneself)" or,
    e. The likelihood of alcohol or drug abuse, and
    f. My written permission is given to release this information, as you deem appropriate in good faith, to specific agencies or persons who are from time to time, authorized by law to receive such information.

**I HAVE READ AND UNDERSTAND THE CONDITIONS OUTLINED ABOVE, AND BY SIGNING BELOW AUTHORIZE Catherine Nickell-Simpson, LLMSW TO OFFER BEHAVIORAL HEALTH SERVICES TO MY CHILD.**

_____ _____
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.**