TREATMENT CONSENT AND ACKNOWLEDGEMENT OF ORIENTATION

Client Name:

Date of Birth:

Case #:

Treatment consent authorizations is being given for:

_____ Self

_____ Parent of child listed above.

Parent Name: ____

_____ Legal guardian of ward listed above
.
Guardian Name: ____

I, hereby, give permission for myself, the above-named minor or other individual for whom I am legally responsible, to receive treatment at The Counseling Center of Wayne & Holmes Counties.

I agree to provide information related to the problems or concerns for which treatment is sought and to participate, as necessary, in the development and implementation of an individualized treatment plan.

Benefits of mental health services may include improved ability to cope with problems of living, skill development in areas such as communications and assertiveness, and growth in the areas of personal goals and values. I understand that to resolve difficult life issues and feelings, treatment may involve discussion of unpleasant experiences and exploration of painful feelings, which can result in increased emotional strain. While I expect benefits from this service, I fully understand that because of factors beyond The Center's control or other factors, such benefits and particular outcomes, cannot be guaranteed.

I understand The Counseling Center is a comprehensive behavioral health center certified through the Ohio Department of Mental Health and Addiction Services to provide a wide range of behavioral health treatment and services. I understand copies of The Counseling Centers orientation materials listed below can be found on the Counseling Center's website.

- Policy on Fees
- Fee Determination Form
- Chart of Patient Fee Levels (fees subject to change at any time)
- Notice of Eligibility
- Residency Verification

Federal Funding Mandate

The Ohio Behavioral Health Information System (OBHIS) is the new reporting system used by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) to monitor certain services to meet Federal requirements for state funding. Providers, like the Counseling Center, are required by law under the ORC 5119.61 and OAC 5122-28-04 to report Information on all clients treated for a mental health or substance use disorder, when services are covered in whole or part by public funding through Medicaid, ADAMH Board or OhioMHAS.

I understand the information sent through the OBHIS reporting program will be used for data collection purposes only.

Informed Consent

I have been informed of how the Center will protect my rights, the rights of my child or ward and safeguard personal information. I also understand the organization may disclose a limited amount of treatment information about myself/child/ward with other healthcare providers to assure service coordination and continuity of care and I agree to the stated terms.

For children: I acknowledge that I am the parent/custodian of this child. I am aware that both parents have access to this child's medical record. If there is a court ruling to prevent such access, it is my responsibility to provide a copy of that document to the Health Information Director of The Counseling Center.

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Signature ____ Date ___________