CLINTON COUNSELING CENTER
Informed Treatment Consent, Recipient Rights, Program Information and Fee Agreement

Mental Health Informed Treatment Consent: I hereby agree to participate in treatment. I agree to receive any of the following treatment as agreed by myself and my therapist: Assessment and Treatment Planning, Individual Counseling, Family Counseling, Case Management; Psychiatric Evaluation, Medications with Medication Management.

Substance Abuse Treatment Informed Treatment Consent: I hereby agree to participate in treatment. I agree to receive any of the following treatment as agreed by myself and my therapist: Assessment and Treatment Planning, Individual Counseling, Family Counseling, Group Counseling, Didactic Lectures, Psychiatric Evaluation, Medications with Medication Management and random Breathalyzer/Urine Drug and Alcohol Testing.

The assessment process is a way for my therapist/case manager to understand me as a whole person by discussing many areas of my life. The treatment planning process will include my input. I have been given the opportunity to discuss these and any other services with my treating therapist. The services have been adequately described to my satisfaction. The risks, benefits and alternative to treatment have been explained. I also understand that the outcomes of treatment cannot be warranted or guaranteed. I hereby voluntarily consent to treatment.

Recipient Rights & Privacy Notice: I acknowledge that I have reviewed/received the following and have had a chance to ask questions: Paperwork Request Policy; Notice of Privacy Rights brochure; "Know Your Rights" Brochure (SA only); Your Rights When Receiving Mental Health Services in MI (MH only); Your Second Opinion and Appeal Rights (MH only); Help When You Need It Book (Medicaid only); Advance Directives for Mental Health Care and Medical Care (Medicaid only).

Hours of Operation: I have been informed that Clinton Counseling Center is open Monday through Thursday from 8:00 am to 9:00 pm, Fridays from 8:00 am to 4:00 pm, and Saturdays from 9:00 am to 1:00 pm.

Emergency Contact: I have been advised that Clinton Counseling Center has an answering machine available during non-business hours. In case of an emergency I can contact the Macomb County Crisis Center at (586) 307-9100.

Treatment Contract: I understand that for treatment to be effective I must participate /attend regularly. I am aware that I must have **at a minimum one face-to-face session (excluding medication reviews) per month to keep my case open.** I understand that to continue medication management at Clinton Counseling Center I must maintain regular attendance with my therapist/case manager. I also recognize that discharge for irregular attendance can occur even if I have made the minimum allowable attendance requirement. Throughout treatment you will be working with your therapist/case manager on plans/services/follow up that will occur at discharge in order to make sure that you have all needed services after your discharge.

Health and Safety: For the health and safety of everyone, I agree to abide by the following policies. I understand that I may be terminated from treatment if I violate these policies.

- No sale, purchase or use of alcohol or illegal drugs on program property.
- No possession of illegal drugs or alcohol on program property.
- No threats or violent acts to staff or others on program property.

- No possession of firearms or other weapons on program property
- The only time prescription medications are permitted on program property are if given a sample by the staff; if staff are copying my medications; or if I must take the prescribed medication while at the agency (in which case I will provide documentation to staff).
- Smoking is only permitted outside by Amvet Street.
- No staff will use seclusion or restraint.
- Staff have shown me the premises including exits; fire extinguishers and first aid supplies

Input from Clients: We value your input. We conduct surveys throughout treatment to gather your input. We encourage you to talk with staff or provide written feedback (in comments box located in the waiting room) to let us know how we are doing and ways we can improve. To assist in this process, please initial one of the following:

_____ I agree to be contacted by Clinton Counseling Center following my discharge from treatment. I understand the information I provide at follow up is confidential and my identity will be protected. I understand I may revoke my consent for follow up in writing, unless action has been taken in reliance on it. This consent expires one year after termination from treatment.
-OR-
_____ I do not want to be contacted by Clinton Counseling Center for follow up services.

Consent for Group Treatment: If my therapist and I deem group counseling to be helpful in my treatment I consent to Clinton Counseling Center discussing information such as my name, diagnosis, progress and compliance and urinalysis and breathalyzer results with other group members. The purpose of this disclosure would be to facilitate effective group treatment. This consent is subject to revocation at any time except to the extent that the person who is to make the disclosure has already taken action in response to it. This consent will terminate upon discharge from treatment.

Payment/Fees: I agree that Clinton Counseling Center may release required information to my insurance company or funding source as necessary to accomplish billing and obtain reimbursement for services. I understand that my insurance benefits have been verified by Clinton Counseling Center as a courtesy and this does not guarantee claim payment. Payment is not guaranteed until the claim is processed with your insurance company. I have been encouraged to verify my benefits with my insurance carrier. I will be responsible for any charges the insurance company or funding source does not cover. I accept responsibility for making payment the day the service is rendered and understand that if my account becomes delinquent, that Clinton Counseling Center may opt not to schedule further appointments until my balance is paid. I understand that failure to pay any outstanding balances within 6 months of notification of charges will result in my account being turned over to a collection agency for collection. I understand that I have the option to set up a payment arrangement in order to avoid having my account sent to a collection agency.

_____ _____/_____/_____
Client Signature Date

_____ _____/_____/_____
Guardian/Responsible Party Signature Date