



FOR INTERNAL OFFICE USE ONLY

**FAMILY SERVICE &
GUIDANCE CENTER**

CLIENT NAME: _____

CLIENT ID: _____

CLIENT GUARDIANSHIP (CHECK APPROPRIATE OPTION):

Client is under 18 Client is 18/older Client is 18/older w/legal guardian Client emancipated

CONSENT FOR TREATMENT

Family Service & Guidance Center (FSGC) uses a team approach for your treatment process. No one on that team is more important than you. Our goal is to collaborate with you in finding treatment options that best fit the needs you have identified. This consent ensures you are aware of & agree to each step of your treatment process during your time as a client with FSGC.

After reading the above statement and discussing the treatment process with a FSGC team member, I agree that I am aware of & consent to each of the following:

- I have the ability to withdraw this consent to treatment at any time & ask for my chart to be closed with FSGC;
 - Participate in a mental health assessment to identify treatment options that align with the needs I have identified;
 - I understand that additional services & supports may be recommended during my time with FSGC & that I have the right to ask questions & gather the information I need before agreeing to add them to my treatment plan;
 - Those services include but are not limited to: therapy, psychological testing, community based services, psychosocial group services, substance use disorder treatment, & medication management;
 - To participate in services using telehealth when appropriate as determined by treatment team and me;
 - I understand the risks involved in using telehealth & have received a copy of FSGC's *Telehealth Services Information Sheet*;
 - I understand that FSGC uses video cameras in some areas of the agency & as a result, I may be recorded.
 - Your treatment sessions will not be recorded unless you give consent first. Video recording is for client & staff safety only & will not be released unless required by law.
 - To have my picture taken for identification purposes only, this will only be used in connection with my medical record; _____ **CLIENT INITIAL** _____ **LEGAL GUARDIAN INITIAL**
 - For my protected health information to be released as needed or requested by insurance for billing purposes; _____ **CLIENT INITIAL** _____ **LEGAL GUARDIAN INITIAL**
- AND;
- That I have received a copy of the Patient Rights and Responsibilities brochure & have been offered the Privacy Practices Information _____ **CLIENT INITIAL** _____ **LEGAL GUARDIAN INITIAL**

Client Signature (age 14 or older)

Client Printed Name

Date

Legal Guardian Signature

Legal Guardian Printed Name

Date

