Consent to Treat
Community Mental Health of Clinton Eaton and Ingham Counties

Consumer Name: AAATestcase, Tommy **Date:** 5/3/2021
ID: 1

Consent

Consent Given by: (•) Consumer ( ) Guardian ( ) Parent

Parent/Guardian Name:

I / my ward / my child agree(s) to participate in the care, treatment, and/or services offered by this agency.

I understand that I will be asked to consent to a plan of treatment and/or service based on individual need, and that some services require additional consent. The development of my treatment plan will be a collaborative process involving myself, and as indicated, my family, mental health staff, other support system(s) and/or other professionals involved in my care. I understand my consent can be withdrawn at any time and participation discontinued at any time.

I have had the care, treatment, and/or services offered, including their purpose, risks, benefits to be reasonably expected, any appropriate alternatives and any further questions I had explained to my satisfaction. I was not given any guarantees as to the results of care, treatment and/or services, which I hereby authorize.

I understand that some of the services I may receive may be provided by telehealth/telepsychiatry services and will not occur face-to face.

I understand if I am receiving psychiatric services that such services may be provided by a psychiatry resident physician under appropriate supervision, and/or services may be provided via telepsychiatry. Telepsychiatry services are provided via video conferencing software with audio capability. Such services may be provided while I am present at a CMHA-CEI facility, or they may be provided to my home or another location as appropriate. During the COVID-19 pandemic, telepsychiatry services may also be provided via telephone without video capability.

I acknowledge receipt of a summary of my rights as a recipient of mental health services, this includes the consumer notice of confidentiality for substance abuse consumers. I have received the agency's Notice of Privacy Practices. These rights have been explained and all my questions have been fully answered to my satisfaction.

I have received information regarding my requirements for participation in treatment and exit criteria from treatment. These have been explained to my satisfaction. I understand that if I am being considered for discharge, I will be notified in writing. I also understand that I have the right to file a grievance or appeal and if not resolved to my satisfaction at the local level, I may request a fair hearing or alternative dispute resolution with the Michigan Department of Health and Human Services.

I have been notified that in accordance with Michigan Law, PA 488 and Community Mental Health policy, that a consumer's blood may be tested for Hepatitis B and HIV (AIDS Virus) in those instances where a professional or agency employee has had an accidental exposure to their blood and/or body fluids. I will be informed of any positive results unless my / my ward's / my child's whereabouts are unknown when the report is received.

For Children's Services: I understand that in the case of joint legal custody following divorce or separation, my ex-spouse has the right to access material in my child's chart.

A new consent must be obtained if changes in treatment or circumstances significantly affect risk, benefits, or other consequences that can be reasonably expected.

Sign

Electronically Signed By:

Name : Elise Magen **Date :** 05/03/2021 4:09PM