Consent for Clinical Treatment & Rights Disclosure - Minor

Groff & Associates, LLC is committed to provide quality, professional mental health care to all of our clients. Your treatment information is handled with the utmost care to ensure your privacy. This document is for consent for clinical treatment and to understand your client rights and the Agency's rights.

I, ______________________________________, hereby attest that I have voluntarily given my consent for the given
(Parent/Legal Guardian First and Last Name)
minor or the person under my legal guardianship at Groff & Associates, LLC, hereby referred to as the "Agency". Further, I consent to have treatment provided by a licensed Marriage and Family Therapist, licensed Mental Health Counselor, or Master's level Resident or Intern in collaboration with his/her approved licensed supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The Agency encourages that this decision be discussed with the treating therapist. This will help facilitate a more appropriate plan for discharge.

Non-Voluntary Discharge from Treatment: You may be terminated from the Agency non-voluntarily if:

A) You exhibit any physical violence, verbal abuse, carry weapons, or engage in illegal acts at the Agency and/or,
B) You refuse to comply with stipulated program rules, refuse to comply with treatment recommendations, do not provide the appropriate forms upon initial treatment, or do not make payment or payment arrangements in a timely manner
and/or,
C) You do not show to your scheduled appointment for two (2) consecutive sessions without notifying the Agency twenty-four (24) hours prior to the scheduled appointment indicating you are unable to attend the appointment.

You will be notified of the non-voluntary discharge immediately. You may appeal this decision with the Clinical Director or request to re-apply for services at a later date.

Client Notice of Confidentiality: The client record and all subsequent protected health information maintained by the Agency is protected by Federal and/or State laws and regulations. Generally, the Agency may not say to a person outside the Agency that you attended treatment or disclose any information identifying you as an alcohol or drug abuser unless:

A) You consent in writing and/or,
B) The disclosure is allowed by a court order and/or,
C) The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State laws and regulations by a treatment facility or practitioner is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State laws and regulations do not protect any information about a crime committed by you either at the Agency, against any person who works for the program, or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child, vulnerable adult abuse, or neglect from being reported under Federal and/or State laws to appropriate State or Local authorities.

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Agency's duty to warn any potential victim, when a significant threat of harm has been made. In the event of your death, your spouse or an authorized minor's parent or legal guardian have a right to access your records.

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Professional misconduct by a therapist must be reported by other therapists, in which case related client records may be released to substantiate disciplinary concerns. Legal custodial parents or legal guardians of non-emancipated minor clients have the right to access your records.

Third-Party Payer Rights: In order for the Agency to contact your insurance company on behalf of your therapist, this consent must be signed by you to enable the Agency pre-authorization to request eligibility and benefit information, to file any insurance claim or process necessary paperwork. Client data of clinical outcomes may be used for program evaluation or with your insurance company, but Protected Health Information (PHI) as stipulated by the Department of Health and Human Services will not be disclosed to any outside sources without a Consent of Release of Information form.

I authorize the Agency to disclose client records to any listed third-party payer for the purpose of receiving payment reimbursement. This includes: health insurance carriers, Employee Assistance Program (EAP) providers, and Church Assistance Program (CAP) Coordinators with affiliated churches. The Agency is not responsible for any client disclosure (i.e. diagnostic information, date of service, billing information, etc.) from a health insurance carrier to the primary insured.

Missed Appointments and Cancellations: If you are unable to keep a scheduled appointment with your therapist, a twenty-four (24) hour advance notification is required. If this notice is not given, the FULL SESSION FEE will be charged for late cancellations or missed appointments.

Payment Due at Time of Service: I acknowledge that all fees are due at the time of service and are to be made out to: Groff & Associates, LLC. Payment can be made by either by: check, cash, authorized credit/debit card, or HSA insurance card. We are not responsible for any HSA insurance card that doesn't approve your treatment. As such, any declined HSA insurance card is the client's responsibility and the client must provide another form of payment at the time of service. Any nonsufficient funds (NSF) received via a check or bank/debit card will result in a fee of Thirty-Dollars ($30.00). When appointment fees are not paid in a timely manner, a collection agency may be given appropriate billing and financial information about you, but will not receive any clinical information. If your insurance company doesn't provide financial reimbursement for your treatment or is cancelled at any time during treatment, you will be responsible for any of the outstanding balance.

My signature below indicates I understand the rights of this Agency and I have also signed a Notice of Privacy Practices form. I consent to treatment and agree to abide by the above stated policies and agreements with the Agency.

______________________________	______________________________
Signature of Parent / Legal Guardian	**Date**
______________________________	______________________________
Printed Name of Parent / Legal Guardian	**Printed Name of Minor Child**