

### Minor Consent Form & Patient Rights and Responsibilities

Consumer's Full Name:	
Date of Birth:	
Social Security Number:	
Medicaid ID Number:	

**Limits of Relationship and Confidentiality:** Relationships between a client and therapist are confidential and protected by law. Exceptions include when a client is in danger to self or others, or when there is a reasonable suspicion of child or elder abuse. There is never any sexual or romantic component between a client and therapist.

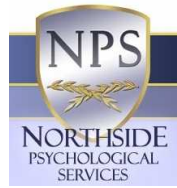
**Consent to Treatment:** I authorize and request that Northside Psychological Services provide psychological examinations, treatment and /or diagnostic procedures for myself/my child, which now or during the course of my care as a client are advisable. The frequency and types of treatment will be decided between my therapist and me. I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement. I understand that there is an expectation that I will benefit from psychotherapy, but there is no guarantee that this will occur. I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy and that the process can sometimes be uncomfortable. I am able and willing to resolve all mental health problems that are assessed.

**Release of information and Authorization for Payment:** I hereby authorize Northside Psychological Services to release information regarding my condition and treatment to Medicare, Medicaid, and/or other insurance carried by the client. I authorize payment or medical benefits to the Northside Psychological Services clinician for services provided.

**Consent to Treatment of Minors:** I hereby represent that I have the legal authority to obtain medical and psychological treatment for the minor child for whom I am requesting treatment. I am a biological parent or legal guardian. In group home or foster family settings, I am designated to authorize treatment. If divorced, I am the primary custodial parent and can secure treatment without the authorization of the other parent.

\_\_\_\_\_  
Signature (Probation Officer/Case Worker/Guardian)

\_\_\_\_\_  
Date

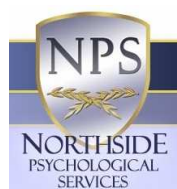


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Your rights as a patient, including confidentiality of your participation in evaluation and treatment services, will be observed in accordance with O.C.G.A. 37-3-166, 37-4-125, 37-7-166, DHR Rules and Regulations for Consumer Rights, Chapter 290-0-9; 42 U.S.C. 290dd-2, and NPS Patient Rights and Responsibilities Policy, NPS program policies and any other applicable laws, regulations, and policies, including the federal Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. A summary of these rules and regulations will be reviewed with you and are available for inspection at each service location. You also will be *provided* a copy of the NPS HIPAA Privacy Notice. This information will be reviewed on an annual basis with you.

### **YOU HAVE THE RIGHT:**

1. To services without discrimination on account of race, religion, sex, ethnicity, age, sexual orientation, disability or cultural background.
2. To exercise all fundamental human, civil, constitutional, and statutory rights to which you are entitled as a legally competent citizen unless such rights are limited under due process of law.
3. To be treated in a manner that respects your individual dignity and protects your health and safety at all times.
4. To receive care that is suited to your needs in the least restrictive environment available that affords reasonable protection from harm, exploitation, and coercion.
5. To receive prompt and confidential services in a respectful and dignified manner even if you are unable to pay, subject to a review of your financial status.
6. To refuse services, after being informed of the potential risks and consequences of refusal, unless a physician or licensed psychologist determines that refusal would be unsafe for you or others, or a court mandates the service.
7. To receive care and treatment suited to your needs in a skillful, safe and humane manner with full respect for your dignity and personal integrity.
8. To a written individualized treatment/service plan.
9. To participate, to the extent possible, in your own care and treatment, to be told your diagnosis, and to participate in the development and implementation of plan of care.
10. To be informed of the benefits, side effects, and risks of psychotropic medications in a manner and language that you can understand.
11. To be given the opportunity to secure legal counsel at your expense.
12. To receive considerate and respectful care and to be free from physical, verbal, sexual, chemical, and mental abuse, neglect, humiliation or mistreatment. Emergency interventions may only be applied when necessary to protect the patients from injury to him/her or others according to the procedures outlined by the organization.
13. To be free from time-out procedures unless such procedures are used solely for the purpose of providing effective treatment to you and protecting your safety and that of others.
14. To be free from isolation, physical, and chemical restraints.
15. Parents/guardians of children or adolescents have the right to be involved on behalf of their children with limited exceptions.
16. To file a complaint without fear of restraint, interference, coercion, discrimination or retaliation.
17. All patients have the right to expect their records are confidential unless you have given permission to give out information or reporting is required or permitted by law. When the organization releases records to others, such as insurance, it emphasizes the records are confidential.



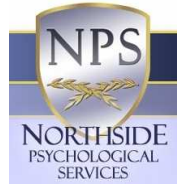
## **Minor Consent Form & Patient Rights and Responsibilities**

### **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY PRIVACY PRACTICES**

18. To access or inspect your health care information unless a physician determines the record review is detrimental to your well being.
19. To obtain a copy of your health care information for as long as the information is retained. (A reasonable fee may apply for copying.)
20. To request in writing that NPS restrict the use and disclosure of your confidential health care information.
21. To receive a copy of the notice of the NPS Practices to Protect the Privacy of Your Health Information.
22. To make a reasonable request in writing to receive communications from NPS by alternative means or locations.
23. To request a list of when and to whom your health care information was released without your authorization within 6 years of your request for non-routine disclosures made on or after July 1, 2007.
24. To request an amendment to your health care information.

### **PATIENTS' RESPONSIBILITIES: AS A PATIENT OF NPS, IT IS YOUR RESPONSIBILITY:**

- ✓ To show consideration and respect towards staff, other patients and the property of others.
  - ✓ To provide accurate information of past and present complaints, past illnesses and hospitalizations, medications, and any perceived risks in your care and unexpected changes in your condition.
  - ✓ To meet financial obligations agreed to with NPS.
  - ✓ To participate in developing your treatment plan including expressing any concerns about your ability to follow the proposed care plan and to ask questions when you do not understand.
  - ✓ To take medications as prescribed.
  - ✓ To accept the consequences of not following the treatment and service plan.
  - ✓ To support the program by participating to the best of your ability and by being on time for all scheduled appointments and activities.
  - ✓ To comply with the rules of the service location.
  - ✓ To respect the confidentiality, privacy, and property of others who are receiving services with you.
  - ✓ To report changes in your condition to those responsible for your care and welfare.
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I \_\_\_\_\_ (Patient Name) have read the above summary of **NPS Patients' Rights & Responsibilities** and have been given the opportunity to ask questions and have been given a copy of this form. I have been offered a copy of the **Notice of NPS Privacy Practices**.

\_\_\_\_\_  
 Signature of \_\_\_\_\_ AM/PM  
 Time  Patient  Legal Guardian  Case Administrator Initial Interview Date

**ANNUAL REVIEW of RIGHTS and RESPONSIBILITIES with Patient/Legal Guardian/ Case Administrator**

_____ Date / Staff Signature	_____ Date / Staff Signature	_____ Date / Staff Signature
_____ Date / Staff Signature	_____ Date / Staff Signature	_____ Date / Staff Signature
_____ Date / Staff Signature	_____ Date / Staff Signature	_____ Date / Staff Signature