Woodland Centers-Consent for Services

Client #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name (Please print) Client Birthdate

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian (If applicable- please print)

**I confirm the following have been offered to me, and I understand I may request a copy at any time, or find the information on the Woodland Centers website at** [**www.woodlandcenters.com**](http://www.woodlandcenters.com) **.**

* Notice of Privacy Practices (Uses and Disclosures of Protected Health Information, Privacy Practices and How to file a complaint)
* Client’s Rights and Responsibilities
* Fee and Payment Information (including Sliding Fee Schedule)
* Electronic Communication (including e-mail, text, and telehealth services)

**I have read and understood the following information regarding my decision to engage in mental health services at Woodland Centers:**

* **Telehealth Services (Psychiatry, Therapy, Mobile Crisis Response, and Substance Use Program):** I may be offered services via telehealth systems that involve the delivery of mental health services by electronic communication with a provider who is at a different physical location. Prior to scheduling telehealth services, I will have the opportunity to discuss the risks and benefits. I consent to these services if appropriate to my treatment with the knowledge that I may decline telehealth services at any time. This service may be dependent on insurance approval and access to mobile devices and computers with high-speed internet access. I understand that either party may not record telehealth services, unless I have given consent and signed a Videotaping Authorization form.
* **Integrated Care:** If I am or will be working with more than one Woodland Centers program or provider, I give consent to all Woodland Centers programs and providers involved in my treatment to share my protected health information, including substance use, in order to facilitate better coordination of services and integration of care.
* **Clinical Trainees/Clinical Interns:** I acknowledge and consent that a Woodland Centers clinical trainee who is pursuing licensure or credentialing may treat my child or me. Services are provided under the clinical supervision of a designated licensed supervisor. The supervising clinician will have access to my records and may join sessions for observation of the intern or trainee. I understand that services are billed at the same rate under the licensed provider/supervisor.
* **Parent/Legal Guardian of Minors: Parental consent is required for all services (including Substance Use Program) unless prior approval is granted based on MN statutes.** I am the parent/guardian of the client and have the legal right to arrange services for the client. (PLEASE NOTE: the other parent with legal rights will have access to the child’s information.) If there is a disagreement between parents regarding services, this must be discussed at the first session. If an agreement for treatment cannot be arranged, Woodland Centers may discontinue services. Our services billed as mental health services are focused on treating the presenting mental or substance use issues and not focused on assessing parenting capacity or documenting disputes between parents. **Woodland Centers reserves the right to require documentation of legal arrangements at any time.**
* **Text/E-Mail Communication:** By providing a cell phone number and/or email address, I am consenting to receiving communications including but not limited to voice message calls, text messages, and emails from Woodland Centers employees. Standard rates for calls or texts may apply.

**By signing, I acknowledge that I am authorizing for Woodland Centers to provide mental health services. Woodland Centers may send my insurance company any information that is needed to determine payment for services. This may include substance use information. I give my insurance company permission to send payment directly to Woodland Centers. I may apply for a reduced fee if I live in Big Stone, Chippewa, Kandiyohi, Lac qui Parle, Meeker, Renville, or Swift county. I understand that to apply for a reduced fee I must submit to Woodland Centers information on my family size and verification of my gross income within 30 days. I understand that I am financially responsible for my bill.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client/Guardian/Parent Signature Today’s Date**