Counseling Associates, Inc.

6960 Orchard Lake Road - Suite 100
West Bloomfield, Michigan 48322
(248) 626-1500

AUTHORIZATION FOR TREATMENT AND/OR COUNSELING AND NOTIFICATION OF CLIENT'S RIGHTS/ORIENTATION

Mission Statement: TO PROVIDE THE HIGHEST QUALITY OF OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES TO THE POPULATION OF SOUTHEASTERN MICHIGAN.
THE BASIC SERVICE IS OUTPATIENT PSYCHOTHERAPY WITH ANCILLARY FUNCTIONS OF DIAGNOSIS ASSESSMENT, PSYCHOLOGICAL TESTING, EVALUATION AND COMMUNITY SPEECHES AND CONSULTATIONS.

I understand that my (my child's) admission to Counseling Associates, Inc. is on a voluntary basis, and I understand and accept the consequences of treatment as explained to me. I am free to decide to accept or reject any special type of treatment, including diagnostic procedures and/or hospitalization, except as required by law, that members of the clinic staff may recommend for me. I have also read and understand my rights as listed below, along with the accompanying orientation.

1. I (my child) have the right to be served without discrimination as to age, sex, race, creed, color, or national origin.

2. I (my child) have the right to have the nature of treatment and any specific risks involved carefully explained to me, especially when the use of potentially hazardous drugs or physical procedures are contemplated.

3. I (my child) have the right to participate in the plans for treatment, goals at intake and throughout treatment. The treatment process and my participation will be documented in the treatment record.

4. I (my child) have the right to confidentiality. Except as required by law, no information, written or verbal, concerning me (my child) shall be released or requested without a dated, signed, and witnessed statement made by me authorizing the clinic to do so. The statement of authorization shall indicate by name to whom, what specific information, and for what purpose this information will be transmitted.

5. I have the right to be notified if services requested cannot be provided. Each request for service shall be acknowledged by the clinic, and if services cannot be provided I will be notified what other resources might be available. I can be discharged if services cannot be provided for my condition, if I am not cooperative in the treatment, or if my behaviors are disruptive to the therapy or to the clinic, or for non-payment of fees.

6. I have the right to communicate freely with my attorney and/or private physician and have information about my treatment made available to them upon my written request/authorization.

7. No medication may be administered except upon the order of a physician.

8. I (my child) have the right to an individualized treatment plan and periodic review to determine my (my child's) progress.

9. I (my child) have the right to have available such treatment as is appropriate to me (my child's) condition. Should the clinic be unable to provide an active and appropriate treatment program, I have the right to be discharged. I may appeal the discharge to the Medical or Administrative Directors.

10. I have the right to ethical treatment by my therapist according to the ethical standards and ethical codes of his/her profession.

11. Any grievance or appeal may occur by filling out an "Incident Report" to be given to the clinic director. See procedure on waiting room wall.

12. I am responsible for all payment of fees incurred and to inform the therapist of all that is essential for the therapist to perform services and work with me.

13. Expections are that the clients will come in for their scheduled appointments, talk about and actively attempt with the therapist to reduce their problems and pay any required fees for services.

14. Hours of operation are from 8:30 A.M. - 9 P.M. Monday - Friday and 8:30 A.M. - 5 P.M. Saturday. Other times may be able to be arranged. After hours services are covered by a 24 hour answering service.

15. Each office has a diagram of the premises with emergency exit routes. Emergency exits are well marked, fire suppression equipment is in each hallway, a first aid kit is in the staff kitchen and therapists can lead clients to emergency shelters.

16. No seclusion or restraint is used. There is no smoking in our building. No illicit or licit drugs may be brought into the program unless prescribed by a physician or are over the counter medications and no weapons can be brought into the premises unless by law enforcement officials who are required to do this.

Print Name: ______________________________

Signed: ______________________________ Date: ______________

Relationship to Patient: ______________________________

____
Witness (Person responsible for coordinating services)

2/08