ADVANCED COUNSELING SERVICES, P.C.

CONSENT AND AUTHORIZATION FOR SERVICES

I, the client or his/her legal, custodial parent, or legal guardian acknowledges that I am voluntarily authorizing treatment for myself, or my child/ward at Advanced Counseling Services. I have been informed of the purpose of the treatment, the services which may be provided, and any attendant risks, consequences, and/or benefits.

Further, I understand the following:

1. I may contact Advanced Counseling Services or the primary clinician as the need arises at the telephone number or address provided to me. If the clinician is unavailable, the program will arrange for contact as soon as possible by the clinician or another professional. In the event of an after hours emergency, I understand I may contact the Wayne County Crisis Center at the number provided to me.
2. Successful termination of treatment is determined when the clinician and the patient agree that the treatment goals have been substantially met.
3. There are fees for the services rendered. I have been informed of those charges and that I am responsible for those charges.
    - If I am entitled to healthcare insurance payments for services received, Advanced Counseling Services may assist me, but assumes no responsibility for collecting insurance payments.
    - If the outstanding balance on my account exceeds $200, services may be canceled until the balance is less than that amount. If this is to occur, Advanced Counseling Services will inform me of this no less than 24 hours before the next scheduled appointment.
    - Patients are expected to fulfill their financial obligation to the program. If payment is not made within 30 days of billing, a 1.5% monthly interest charge may be attached to my account. Failure to pay outstanding balances may result in the client being discharged from treatment.
    - A services charge of $15 will be added to your account if your account is sent to our collection agency.
4. I understand that, in general, Advanced Counseling Services provides outpatient services for mental health and substance abuse issues. Further, I understand that the hours of the program are from 8:30 a.m. to 9:00 p.m. Monday through Friday, and 8:30 a.m. to 5:00 p.m. on Saturday. Hours are by appointment.

Rights Related to Substance Abuse Services

1. If the services I am to receive relate to substance use issues, I acknowledge that I have received a copy of the pamphlet "Know Your Rights" developed by the Michigan Department of Community Health / Center for Substance Abuse Services. These can also be found at www.michigan.gov/recipientrights.

Rights Related to Mental Health and Substance Use Services

I recognize that persons who receive mental health and/or substance use related services have the right:

- To be served without discrimination as to age, sex, race, creed, color, culture, or national origin as long as persons receiving services meet the organization's admission criteria for indicated services regardless of the source(s) of financial support.
- To all rights guaranteed by state and federal law.
- To be informed of his/her rights in a language he/she and, as appropriate, his/her family understands;
- To be treated without neglect or abuse and with respect and dignity regarding personal values and beliefs.
- To be informed of rules and regulations regarding conduct.
- To an investigation of complaints, if any.
- To obtain a copy of his/her case record, unless the Medical Director recommends otherwise.
- To refuse to be a part of any research project.
- To confidentiality, except as required by law.
- To appropriate care, to be notified if any indicated services cannot be provided by the organization, to be notified of other resources, if any might be available, and to be discharged from the organization.
- To have his/her case record made available upon properly executed written authorization.

- To refuse any procedure, treatment, or medication. Such refusal on its own shall not be grounds for dismissal from the program or its services.
- To participate in and/or, as appropriate, have family participate in the development of an individualized plan of treatment and services, and in decisions regarding care and services, and to obtain a copy of the Treatment Plan.
- To participate in the consideration of ethical issues arising in the providing of care and services.
- To periodic review of his/her plan of treatment to determine progress in treatment.

Responsibilities

I understand and acknowledge that persons receiving services have certain responsibilities, including;

- To help develop a plan of treatment.
- To sign forms (when in my or my dependent's best interest) for the release of information pertaining to me or my dependent.
- To suggest changes for the improvement of the services, when appropriate.
- To comply with the provisions of this Consent and Authorization for Services.
- To carry out the provisions of my Treatment Plan.

Confidentiality

Current HIPAA regulations and State regulations for mental health and substance abuse shall be enforced (see HIPAA Omnibus Rule and State of Michigan Mental Health Code). No information, written or verbal, concerning the persons receiving services may be released or requested without a dated, signed, and witnessed statement made by the person receiving services or, as appropriate, by his/her legal, custodial parent(s), or legal guardian EXCEPT:

- In case of a medical emergency.
- According to State law; certain communicable diseases must be reported to the Michigan Department of Community Health.
- If there is suspected child abuse or neglect and/or elder abuse or neglect that must be reported to either the Department of Social Services or the police department.
- If there is a legitimate threat to harm another person or the community, the program must notify that person and may notify the police department of such intended action.

The confidentiality of the records of persons being treated or having been treated for alcohol and/or other drug problems are protected by Federal law and regulations. Generally, a program may not say to a person outside of the program that a patient attends or has attended the program, or disclose any information identifying a patient as an alcohol abuser UNLESS:

- The person receiving services or, as appropriate, his/her parent(s) or guardian consents in writing.
- The disclosure is allowed by a court order.
- The disclosure is made to qualified personnel for research, audit, and/or program evaluation.
- The disclosure is made to medical personnel in the event of a medical emergency.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.
Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threats to commit such a crime.
Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

Discharge/Termination

1. I understand that I may be discharged from services at Advanced Counseling Services for the following reasons:

- I or my dependent completes the planned course of treatment with an acceptable degree of success.
- I choose to terminate.

- The therapist feels that termination is the most reasonable option, given my particular response to treatment.
- Other circumstances make it necessary to discontinue treatment due to hardships or impracticality (e.g. job transfer or family relocation).
- Services cannot be provided in a professional and ethical manner, and in compliance with the standards of all regulatory bodies.
- I or my dependent fails to maintain contact with the program for a period of more than 30 days.
- I or my dependent fails to comply with the provisions of the Consent and Authorization for Services.
- I or my dependent violates one of the program rules which identifies that to do so will result in discharge.

2. I have reviewed the following program rules, and agree to abide by them:

- Clients are expected to keep all scheduled appointments. Advance notice is expected when a cancellation is anticipated. At the discretion of the primary clinician, Medical Director, or Chief Executive, my or my dependent's repeated failure to attend the program may result in case closure.
- Possession and consumption of substances; including alcohol and non-prescription medications, are prohibited from the program's premises. Continued use of mood altering substances may result in discharge from the program.
- Selling or illegal substances on the premises will result in the program staff contacting the police and filing charges for illegal behavior.
- Medication seeking behavior, doctor shopping and using multiple pharmacies may result in termination from the program.
- Smoking is not permitted in any offices of Advanced Counseling Services or the building in which its offices are located.
- Clients are required to refrain from disorderly conduct in the offices and building. Physical and verbal abuse, and/or exploitation will not be tolerated. Such action will result in discharge from the program with appropriate police action sought.
- Deliberate deception and manipulation may be interpreted to be a lack of investment in treatment and may result in discharge from the program.
- Clients are to refrain from wandering around the building in which Advanced Counseling Services is located. The reception area is available for our clients' comfort. Under no circumstances shall a client enter a clinical area or a records storage area without staff approval.
- Clients are expected to inform their primary clinician and the consulting physician of any and all medications they are taking.

Authorizations to Communicate

I understand Advanced Counseling Services will communicate with my health insurance company and/or its agents regarding coverage which may be applicable to services received by me or my dependent(s). I further authorize the program to release information to my insurance company or its designated agents about services rendered and to forward statements of charges and payments, as appropriate, to my health insurance company, its agents, to my home, or to the program.

I authorize Advanced Counseling Services to contact me by telephone, mail, or text message. Follow-up contacts may occur regarding satisfaction with the services provided.