INFORMED CONSENT AND INVOLVEMENT IN CARE

I understand that by signing this document I/we understand and agree to the following:

- I and/or my child will be receiving counseling/psychotherapy services to address the problems I or my child have chosen to address, which will be outlined in a treatment plan. Inherent in this are decisions to change my life or that of my child's life and mental health.
- I and/or my child will be involved in the development of the treatment plan. The goals created will be to promote a happier, healthier life for myself and/or my child.
- There are risks I am willing to take for myself and/or my child. These include, but are not limited to, an initial decline in mental health. I and/or my child's mental health could decline to the need for medication or hospitalization. I or my child could make decisions to change, which may or may not be to me or my child's benefit.
- The choice of provider is mine/my child's and I know that here are other providers I could choose. I understand I can refuse the services offered. I am choosing A New Beginning Wellness Center as my provider of choice.
- Services are provided at a time and location that are convenient, acceptable, and suitable to the client and the provider. The services are to be coordinated, consistent and not a duplication of services.
- Primary financial responsibility is mine. If Medicaid does not pay for services, due to a lapse in coverage due to my oversight, I will be expected to pay for the services provided during the lapsed time.

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Client Date

_____

Parent/Guardian Date