New Focus

Consent to Treat & Acknowledgement of Receipt of Rights

I, (name of client)_____, agree to participate in the assessment and/or counseling services offered by Child and Family Charities' *New Focus* program. Counseling may include individual, group, and/or family counseling. I understand that my consent may be withdrawn and I can stop counseling at any time. The possible consequences of such actions have been discussed with me.

In addition, I understand that: (Please initial on each line)

_____The assessment and counseling services offered, including the purpose, potential benefits and any alternatives have been explained to me. I have had a chance to ask questions.

_____I have received the ***Know Your Rights*** **brochure**. My rights have been explained and all of my questions have been answered to my satisfaction. **Medicaid Recipients Only:** I have been made aware of the Grievance and Appeal process.

_____I have received the ***Behavioral Health Division Program Information Brochure*** which informs that at least two or more hours of individual or family counseling are available to me each week, if needed. The agency is open Monday – Thursday 8:30 AM-7:00PM and Friday 8:30AM-5:00PM.

_____I have received information regarding communicable infections, such as sexually transmitted infections, hepatitis, and tuberculosis. I have also received information about where I might receive confidential and low cost screening and testing.

_____I have received a copy of the ***New Focus Substance Use Disorders Counseling Services brochure***, which includes *reasons for discharge, fee information, and cancel and no show fees,* if applicable to me. Below is specific information related to discharge:

- I understand that my therapist has the right to discharge me for the following reasons:
  - I have completed the planned course of treatment with acceptable success.
  - I fail to follow the agency rules, which include any threats of or actual physical violence toward staff or other clients,
  - I come to Child and Family Charities under the influence of any drug or alcohol.
  - My therapist does not have any contact with me for 30 days.
- I understand that I will be notified before I may be discharged and the reason for It, either in person or in writing.
- I understand that I may request a review or appeal a discharge decision. This will initiate the recipient rights process and will be reviewed according to the Administrative Rules for Substance Abuse Programs in Michigan, promulgated under Michigan Public Act 368, 1978, section 3 – Recipient Rights (effective Jan. 9, 1982). These rules and your rights are further explained in the Rights brochure you receive.

_____I have received a copy of the **MSHN Member Handbook** and a current **Provider List**.

_____If I am 18 years of age or older, I have received a copy of the **Advance Directive brochure** and have had an opportunity to ask questions. At the present time, I ☐ DO / ☐ DO NOT have an Advance Directive.

_____I have voluntarily chosen to receive services at Child and Family Charities New Focus Program.

_____ I agree to follow the treatment plan as discussed with my therapist. I recognize that my treatment may be discontinued by the Agency is I do not comply with the treatment plan. Other treatment alternatives may be offered if I do not agree with the treatment plan.

_____ _____

Client Signature (required if client 14 and older) Date

_____ _____

Parent/Guardian Signature (required if client 13 and younger) Date