Focus Mental Health Services
1127 N. Kickapoo
Shawnee, OK 74804
405-214-0116
www.focusmhs.com

INFORMED CONSENT FOR TREATMENT

Application is hereby made by the undersigned for voluntary admission to the services of Focus Mental Health Services, LLC (Focus MHS).

1. I / We (parent, legal guardian) authorize associates of Focus MHS to administer treatment (i.e. counseling, and/or neurofeedback) and continue such treatment as deemed professionally necessary.
2. I / We understand that this consent is given before any specific diagnosis or treatment is given. The professionals of Focus MHS exercise their judgment in determining the diagnosis, developing a treatment plan and in providing treatment.
3. I / We agree to be actively involved in the treatment plan as developed by the professional of Focus MHS while I / We receive treatment. I / We understand that included in this treatment plan would be my involvement in regular individual, family or group therapy sessions as recommended.
4. I / We understand that the purpose of counseling is for the betterment of myself and/or my family. It is not intended to be used as a tool or weapon for divorce, custody, disability, or other litigation. If I request copies of my records or the testimony of my therapist for such purposes, there will be a separate financial fee for which I agree to be responsible.
5. I / We agree to be contacted by Focus MHS administrative personnel for the purpose of monitoring quality of services provided and accuracy of Focus MHS billing.
6. No guarantees have been given to me as to the results that may be obtained.

ACKNOWLEDGMENTS AND SIGNATURE

1. I / We have read (and received upon request) a copy of the Client Rights.
2. I / We have read (and received upon request) and understand the Limits of confidentiality.
3. I / We have read (and received upon request) a copy of the HIPPA Policy.
4. I / We have read the consent for treatment and understand all of its contents and sign my name freely, voluntarily and without coercion.
5. I / We agree to give 24 hours notice of cancellation if not able to participate in planned services. The treatment plan may be reviewed to determine the appropriateness of continued treatment or possible discharge.

Client Name (Printed) _____ DOB _____ ID Number (Medicaid) _____

Client Signature _____ Therapist Signature _____

Parent/Guardian Name (Printed) _____ Parent/Guardian Signature _____

Date _____ Date _____