Common Ground
helping people move from crisis to hope

Consent for Treatment
OCIRT

Client Name: _____ **Case Number:** _____

NOTE: Please read the following statements carefully. Ask any questions you wish to help you understand each statement. Your signature at the bottom of this form indicates agreement with each statement, and is your permission for us to provide services as indicated below.

I authorize the health care professional assigned to me to provide treatment and/or recommendations, as the professional considers necessary and proper. I realize that treatment does require a mutually agreed-upon Person/Family-Centered Plan of service and that my/our participation in the development of this plan is essential.

I understand that through implementation of this Person/Family Centered Plan, my/our worker will assist me/us in understanding all procedures used, any possible risks, the purposes of treatment, any discomfort, the reasonable expected benefits, and any alternatives to treatment, which may be helpful. I/we agree to participate in this Person/Family Centered Plan voluntarily, and I/we understand that my/our consent to treatment may be withdrawn by me/us at any time.

I understand that my records will be kept confidential and agree that my records and progress may be presented for supervisory process.

I have been advised of my rights, under the law, as a recipient of services from, an Oakland County Community Mental Health Authority contracted provider. I have also received a copy of "Your Rights" booklet.

I understand that my healthcare information may be shared between, a contracted health provider of Oakland Community Health Network (OCHN) and other OCHN Core Provider Agencies, to assist in the coordination of my treatment. My healthcare information may also be shared with my Primary Health Care Physician (PHCP) and Medicaid Healthcare Plan (MHP). In addition, my healthcare information will be shared with OCHN to assure payment, confirm benefit entitlements, determine medical necessity, and validate orders and charges.

I understand that if I am a parent of a minor child, that I am expected to participate in my child's treatment.

I have been advised and understand that according to Chapter 8 of the Mental Health Code, it is my responsibility to provide accurate and complete information about my financial status. Failure to do so may mean I am totally responsible for the full cost of all services provided by including medications and tests my psychiatrist may prescribe. (You may request a copy of Chapter 8) Furthermore, understand that Michigan stature MCL 3353.5133 permits an HIV Antibody test to be performed upon an individual without the written consent generally required for HIV Antibody Tests (AIDS) if: there is a Common Ground employee exposed to blood or body fluids

I understand that this consent expires one (1) year from the date of my signature below.

Signature: _____ **Date:** _____