Informed Consent for Psychiatric Treatment

Consent to Treatment

I voluntarily agree to receive mental health care, assessment, and treatment, and I authorize Healthy Minds to provide such necessary care. While I expect benefits from this treatment, I fully understand and accept that such benefits cannot be guaranteed because of factors beyond our control. I understand that regular attendance will produce the maximum possible benefits. I agree to participate in the planning of my care, and I understand that I may stop treatment at any time by informing my treatment provider. I have received a copy, read, and understood all the terms and information contained in the Notice of Privacy Practices.

Access to Information in Child Psychiatry

Psychiatrists specializing in working with children know it is important to treat children in the context of their family. Participation of parents, siblings, and sometimes extended family members or other important adults is common and often recommended. In treatment involving children and families, access to information is an important and sometimes contentious topic because trust and privacy are crucial to treatment success. This is especially true when treatment involves older children or families with open child-welfare cases. Parents, fictive kin, legal guardians, and/or agencies responsible for child welfare (DFS, when involved) need to know certain information about treatment. For example, when families have an open child-welfare case, DFS caseworkers often request certain information to help make case plan decisions and write court reports. For this reason, we need to discuss and agree what information Healthy Minds will share, with whom we will share the information, and what information will remain private (i.e., not released to the parent, legal guardian, and/or DFS).

In addition to signing this agreement, Healthy Minds will note in the chart any additional verbal agreements regarding access to records and limits of confidentiality. We will treat this agreement as legally binding, although a judge may override this agreement in the future. Under this agreement, when there is an open child-welfare case, Healthy Minds will proceed as though only the following individuals hold privilege on behalf of the child and may request access to information:

- Parents or fictive kin (when parental rights are not terminated)
- Medical Case Management Unit personnel
- DFS Placement worker (when applicable)
- DFS Permanency worker
- DFS administrator
- Probation officer (when applicable)
- District attorney

The Notice of Privacy Practices details the limits of confidentiality. Additionally, when there is an open child-welfare case, we will inform DFS on a monthly basis about treatment attendance, engagement, diagnosis, medication additions or changes, goals, progress, risk factors, and transfer or termination of treatment. When requesting information, the requestor must always inform Healthy Minds specifically what information is to be

released, who will have access to the records, and how the information will be used. At the end of treatment, we can prepare a summary for the parent, fictive kin, and/or legal guardian.

We will always inform the parents and/or legal guardians if we think that the child is in danger or if he/she is endangering others. In our first meetings, we must discuss and agree on a shared definition of dangerousness so we are clear about what will be disclosed. In the interest of clarity regarding what will be disclosed, we present on the next page some benchmarks in determining a serious risk of physical harm. An exhaustive list is not possible, so we will exercise professional judgment in interpreting and applying this description of serious risk of physical harm. The parent and/or legal guardian may alter this agreement on a case-by-case basis and demand disclosure of specific information upon giving written consent at the outset of treatment. If the parent or legal guardian changes its mind in the middle of treatment, Healthy Minds may determine that it is in the child's and/or family's best interest to terminate the therapeutic relationship and transfer them to another provider to resume treatment and protect confidentiality based on the original terms of this agreement.

serious risk – disclose	**not a serious risk – do not disclose**
habitual, life-threatening intravenous use of heroin or meth with moderate likelihood of death	recreational marijuana or alcohol use
ongoing pattern of indiscriminate, sexually-promiscuous behavior	pregnancy
plan to take weapons to school while fantasizing about attacking others	habitual school truancy or theft
suicidal thoughts with intent to carry out a plan	passive suicidal thoughts with no plan
sexually-explicit conversations and petting with a much younger child or a child with a developmental delay	superficial cutting
contact with minor while declared a runaway	plan with intent to run away
report that parent has had no food or running water in the house for two or more days	parent fails to pay power bill and makes adaptations
	moderate, latent, or vague risk of harm

Acknowledged Consent

Healthy Minds is a multidisciplinary group composed of psychiatrists, psychologists, marriage and family therapists, licensed clinical social workers, and other mental health providers. In order to provide the best possible care, the details of your treatment will be shared among Healthy Minds providers. You may contact any of our personnel at any time regarding treatment.

Permission for Release of Information

I give Healthy Minds permission to release information about my treatment to:

_____.

I understand that I do not have to release these records but that refusing to do so may result in a less accurate diagnosis and treatment plan. I understand that this release includes all diagnoses, discharge instructions, physical exam findings, laboratory and radiology results, psychosocial assessments, and treatment plans. I understand that once my health information is released to the parties listed above, Healthy Minds cannot guarantee that the information will not be released to someone else or as required by law. I understand that I may change my mind at any time and cancel this authorization by providing a written notice to Healthy Minds. I understand that if I do not cancel this authorization, it will end one year from the date below. I have read and understand this authorization and had all of my questions answered. This release is reciprocal, so all names listed may release information to each other. A photocopy of this release is as valid as the original.

I understand that Healthy Minds is a training site for various specialties and that I may be seen by an intern, resident, or fellow trainee. I understand that the trainees are supervised at all times by licensed professionals. _____Initial

I consent that documents containing my clinical information may be transmitted via email, which may not be entirely secure. _____Initial

I understand that information regarding my appointment, or that of the minor in my care, may be left on a voicemail of the phone numbers that I provide, or that I sign a release of information for. _____Initial

If I do not show up for my appointment, or I fail to cancel an appointment by calling ahead at least 24 hours in advance, I agree to pay 50% of the appointment fee. _____Initial

If the biological parents are separated or divorced, who has legal custody of the child? If legal custody is shared, if the other parent has legal custody, or if you do not know the legal status of your child, you must discuss this with your doctor at the first appointment to make arrangements to ensure no one's legal rights are violated.
mother _____ father _____ I don't know _____ not applicable _____

Are there court documents dictating legal or financial responsibility for the child's healthcare? If yes, you must discuss this with your doctor and bring them to your next appointment or else the doctor will not see your child.
yes _____ no _____ I don't know _____ not applicable _____

My signature below indicates that I have read, understood, and agree to the information in this document.

Child's Printed Name	Child's Signature	Date
Legal Guardian's Printed Name (Required)	Legal Guardian's Signature	Date
Physical Custodian's Printed Name	Physical Custodian's Signature	Date
Parent's Printed Name (only if not Legal Guardian)	Parent's Signature	Date

HEALTHY MINDS
5516 S. Fort Apache Rd. Suite 100, Las Vegas, NV 89148
Ph: (702) 646-0188 Fax: (866) 518-0781 FAscheduling@HealthyMindsLV.com