Old Mill Center for Children and Families
1650 SW 45th Place
Corvallis OR 97333-1768
PH: (541) 757-8068 Fax: (541) 758-1030
www.oldmillcenter.org

Consent to Treat

Client Name: _____

Date of Birth: _____

Please review and initial the fields below.

1. _____ **Consent for Assessment and Mental Health Services**: I grant permission for Old Mill Center's (OMCCF) counseling staff to provide assessment and mental health services to my child. I understand that services will be provided by a qualified mental health professional or counseling intern receiving clinical supervision by a licensed professional counselor. It is agreed that assessment, services, and support will follow guidelines specified in my child's individual services and support plan (ISSP). I will assist in the assessment of my child, determining the plan for services, and reporting progress toward goals. I may request and receive a copy of my child's ISSP at any time. I may ask for additional information about and take part in my child's services.
   The goal of the mental health services OMCCF provides is to help create positive and lasting changes for children and families. While efforts are made to reduce risks associated with counseling, I am aware that there are risks involved. Families sometimes experience an increase in stress, particularly during the early stages of mental health services. The emotional status and behavior of my child may worsen at times. When services involve group activities with other children, I understand that, as with any group of children, there is risk of injury from aggressive children or accidental injury during activities or travel.
2. _____ **Legal Custody**: OMCCF will request a copy of current court papers if they are needed to ascertain who can legally consent for the minor child. OMCCF will attempt to seek consent from each of the minor child's parents or guardians when there is more than one who have shared legal custody.
3. _____ **Right to Withdraw Consent**: I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.
4. _____ **Authorization for Release of Medical Information**: I authorize OMCCF staff to release medical information about my child requested by insurance companies with whom I have coverage, or any public agency and/or its agents to determine benefits for services provided or benefits for related services. I understand that the amount and type of information shared depends on the requirements of that company or agency.
5. _____ **Assignment of Benefits**: I hereby authorize payment of benefits to be made directly to Old Mill Center for Children and Families. OMCCF accepts this assignment.
6. _____ **Privacy Policy/Individual & Family Rights and Responsibilities Statement**: I have been made aware of the Old Mill Center for Children and Families' Privacy Policy and of their Individual & Family Rights Statement.
7. _____ **Acknowledgement Statement**: I confirm that the contact and insurance information I provided is accurate. I will inform OMCCF of any changes in the future.

_____ _____ _____
Signature of Responsible Party **Relationship to Client** **Date**

_____ _____ _____
Signature of Responsible Party **Relationship to Client** **Date**

_____
Print Name of Client