LifeLens Psychological & Counseling Services
Service Agreement
(Consent and Authorization for Services)

Client Name: _____ **Acct #** _____

I, the client or his/her legal, custodial parent, or legal guardian, acknowledge that I am voluntarily authorizing treatment for myself or my child/ward at LifeLens Psychological & Counseling Services. I have been informed of the purpose of the treatment, the services which may be provided, and any attendant risks, consequences, and/or benefits.

I recognize that persons who receive mental health and/or substance use related services have the right:

- To be served without discrimination as to age, sex, creed, race, culture, or national origin as long as persons receiving services meet the organization's admission criteria for indicated services regardless of the source(s) of financial support.
- To all rights guaranteed by state and federal law.
- To be informed of his/her rights in a language he/she and, as appropriate, his/her family understands.
- To be treated without neglect or abuse and with respect and dignity regarding personal values and beliefs.
- To be informed of rules and regulations regarding conduct.
- To an investigation of complaints, if any.
- To obtain a copy of his/her case record, unless it is contraindicated as determined by the Director.
- To refuse to be a part of any research project.
- To confidentiality, except as required by law.
- To appropriate care, to be notified if any services cannot be provided by the organization, to be notified of other resources, if any might be available, and to be discharged from the organization.
- To have his/her case record made available upon properly executed written authorization.
- To refuse any procedure, treatment, or medication. Such refusal on its own shall not be grounds for dismissal from the program or its services.
- To participate in and/or, as appropriate, have family participate in the development of an individualized plan of treatment and services, and in decisions regarding care and services, and to obtain a copy of the treatment plan.
- To participate in the consideration of ethical issues arising in the providing of care and services.
- To periodic review of his/her plan of treatment to determine progress in treatment.

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Current HIPAA regulations and State regulations for mental health and substance abuse shall be enforced (see HIPAA Omnibus Rule and State of Michigan Mental Health Code). No information, written or verbal, concerning the persons receiving services may be released or requested without a dated, signed, and witnessed statement made by the person receiving services or, as appropriate, by his/her legal, custodial parent(s), or legal guardian except:

- In case of a medical emergency.
- According to State law; certain communicable diseases must be reported to the Michigan Department of Community Health.
- If there is suspected child abuse or neglect and/or elder abuse or neglect that must be reported to either the Department of Social Services or the police.
- If there is a legitimate threat to harm another person or the community, the program must notify that person and may notify the police of such intended action.

I understand that LifeLens Psychological & Counseling Services will communicate with my health insurance company and/or its agents regarding coverage that may be applicable to services received by my dependent(s) or me. I further authorize the program to release information to my insurance company or its designated agents about services rendered and to forward statements of charges and payments, as appropriate, to my health insurance company, its agents, to my home, or to the program.

I understand that I am financially responsible for services rendered and agree to pay for cost of treatment either through my insurance carrier or on a cash basis. I acknowledge that it is my responsibility to remain current with co-pays, co-insurance, or cash basis payment. I understand that if my insurance carrier fails to reimburse for cost of care that I am responsible for cost of treatment. I understand that I am responsible for any and all late cancellation / no-show fees assessed.

I authorize LifeLens Psychological & Counseling Services to contact me by telephone, email, postal services, or text message. Follow-up contacts regarding satisfaction with the services provided are also authorized.

_____ _____

Client signature / Responsible Party Signature Date

_____ _____

Witness Signature Date

LifeLens
Psychological & Counseling Services