SPARKS

Starfish Family Services

STARFISH FAMILY SERVICES

Starfish Family Services & University Physician Group Consent for Treatment – CMH Programs

IDENTIFYING INFORMATION				
NAME	DOB	CASE #	MEMBER ID	GENDER

DATE

CMH - STARFISH, PRIVATE OR YAP

☒ CMH ☐ Private ☐ YAP

I, the undersigned,

1. Voluntarily consent to treatment as recommended and fully explained to me by staff of Starfish Behavioral Health Services (BHS) and understand that I am free to withdraw my consent and discontinue treatment at any time.
2. Understand that I have rights as a recipient of counseling services and have received the following information: the **"Your Rights When You Receive Mental Health Services"** brochure, the **"Client Rights"** brochure, the **"EPSDT Screening"** brochure, and the **"Rights and Responsibilities"** brochure for Medicaid recipients. I understand that I may receive additional information about my rights from the Recipient Rights Advisor identified to me as:

   Detroit Wayne Integrated Health Network

   Office of Recipient Rights

   707 West Milwaukee Street

   Detroit, MI 48202

   1-888-339-5595 or (TDD) 1-888-339-5588
3. Understand that there are informal conflict resolution processes that I can access by calling the privacy officer or requesting to speak to a supervisor to resolve any concerns or problems that I have.
4. Understand that the privacy practices described in the **"Notice of Privacy Practices"** which I have been provided a copy of and been given the opportunity to review, may change over time, and that I have a right to obtain any revised Privacy Notice by contacting the Privacy Officer at 734-728-3400.
   - I may restrict how my health information is used or disclosed. Starfish does not have to agree to my request for the restriction, but if Starfish does agree, Starfish is bound to abide by the restriction.
   - I have the right to revoke/withdraw this consent, in writing, at any time. Starfish cannot take back any uses or disclosures already made with your permission prior to this withdraw. Provision of future treatment may be withdrawn if I withdraw my consent.
5. Understand that the confidentiality of records maintained by Starfish is protected by 42 CFR Part 2 Federal Regulation. Program staff may not disclose any identifying information to outside sources regarding a client's treatment unless the client gives consent.
   - Research activities and program evaluation: Personnel may not identify directly or indirectly any individual client in any report or otherwise disclose client identities in any manner;
   - Management and financial audits: Examiner must furnish to the program a written statement that no record will be made of client identifying information unless notice is provided to the program and, if necessary, setting forth the specific purpose for which identifying information is being retained, how it is to be retained and the contact person;
   - Payment for the treatment/services provided: information will be used to obtain payment for services that Starfish BHS provides.
6. Program staff may be required to release client information without client consent under the following specific conditions:
   - Client threatens to harm self or others;
   - Suspicion of child abuse and/or neglect;
   - Medical personnel, to meet a bona fide medical emergency when there is immediate threat;
   - Authorized by court order under Subpart E
7. Acknowledge that any violent or hostile behavior as well as any threatening verbal and non-verbal behavior will result in discharge. I understand that possession of a weapon or other contraband on clinic property is prohibited. I understand and have been advised of additional program policies regarding conditions under which I may be discharged. I further understand that I have the right to appeal this action to the clinical manager within 30 days from which it occurs.
8. Understand I am to follow through to the best of my ability in developing and achieving treatment goals/objectives, as agreed upon by my therapist and myself. I understand that if I fail to follow through on significant parts of my Individual Plan of Service, possibly resulting in harm to myself or others, my therapist may choose to refer me to a more appropriate treatment setting.
9. Acknowledge that excessive no calls/no shows or cancellations of appointments may lead to a change in my scheduled appointment and/or discharge from treatment.

10. Understand that I have the right to speak to the Clinic Director or Recipient Rights Advisor at any time I feel my rights have been violated.
11. I acknowledge that I have disclosed all information regarding my health insurance. I further acknowledge the insurance information to be accurate and complete. I accept the responsibility for my fees, changes in insurance, and for all services rendered to me.
12. Agree to have my child seen by a Starfish BHS therapist, case manager, or supports coordinator in their school or home, if clinically necessary.
13. Agree to respect the confidentiality of other clients attending the Clinic.
14. I have been explained and understand the Medicaid Grievance / Dispute Resolution Process.
15. I have been explained and understand my rights under the Person Centered Planning Process.
16. I have been informed of respite services and will be referred by my therapist and/or case manager if I wish to receive respite services.
17. I have been given information/application for MI Child (if applicable).
18. I acknowledge that this consent to treat will stay intact until this case has been discharged from treatment.
19. If at any point in treatment it is identified that the client or parent of a client is an employee or volunteer at Starfish, clinical treatment will be transferred to another agency to protect that person's right to confidentiality.
20. To the best of my knowledge, I am providing Starfish with the most current custody information and I have the authority to give my consent to have my child/minor treated at Starfish.
21. I acknowledge the receipt of the Coordination of Care brochure.
22. I agree to allow follow up calls from Starfish staff up to 6 months after discharge for purposes of re-engagement.
23. Understand that Starfish BHS may coordinate my treatment services with University Psychiatric Group (UPG) and when deemed clinically necessary my child will be seen by a UPG psychiatrist.
24. I understand that even if I opted out of reminder texts/calls, I will be contacted via text message in the event of a clinic closure to alert me that my appointment will be canceled due to the closure.

With my signature I acknowledge that I have read, understand and agree to the above statements numbered 1 through 24.

I ACKNOWLEDGE THAT THE CONSUMER HANDBOOK HAS BEEN PROVIDED/MADE AVAILABLE TO ME.
☐ Yes ☐ No

Substance Abuse Treatment Clients:

I have received a copy of the **"Know Your Rights"** Pamphlet and the **"Confidentiality of Alcohol and Drug Abuse Client Records"** handout

☐ Yes ☐ No ☐ N/A

SIGNATURES

STAFF SIGNATURE / CREDENTIALS _____ DATE _____

CLIENT SIGNATURE _____ PRINTED NAME _____ DATE _____