MAPLE STAR NEVADA
CONSENT TO TREAT

General Consent

I consent to be treated by the staff of Maple Star Nevada, and grant authority to the staff members to perform any examinations, diagnostic procedures, treatment, or other services which may, during the course of my care, be legally, ethically and clinically compelling. Maple Star Nevada's services include:

- Assessments
  - Adult/Child Psychosocial Mental Health Assessment
  - LOCUS / CASII
  - Substance Abuse Assessment: ASAM and SASSI
  - Psychiatric
  - Treatment Plan: Will be reviewed with me before treatment begins, and at 30 or 90 day intervals
- Psychiatric Services/Medication Management
- Individual, Family, Group Therapy
- Rehabilitation services: Basic Skills Training, Psychosocial Rehabilitation, Day Treatment, Group Rehabilitation services

I understand that I may refuse any or all services if l so choose. I also understand that my active involvement and effort is essential to the success of my treatment. Maple Star Nevada may make changes in my treatment including, upon proper notification, the reduction or termination of treatment services.

Limits of confidentiality**:** If I reveal information that leads to suspected child or elder abuse, if I am suspected of being dangerous to myself or someone else, or if my illness or the medication I am taking affects my ability to drive, I understand that staff members are required by law to notify the proper authorities. I also understand that treatment records could be obtained without my consent after due process through a court order.

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a treatment program, as the use of some medically prescribed medications used in conjunction with substances or psychotropic medications prescribed by a Psychiatrist may cause me harm.

I understand that Maple Star Nevada has a no call/no show policy. In the event I miss an appointment without calling 48 hours prior to my appointment, or I am not present on time for a scheduled appointment for a total of 3 times, I will be referred to another provider. Emergency situations will be considered on a case-by-case basis.

I understand that the records regarding my treatment are the property of the agency that provides my care and that such records or other information about me and my treatment may be released only upon my written authorization. I may request a copy of my records by completing and submitting a records request form.

I give my permission for Maple Star Nevada to release any information necessary for the purpose of billing insurance, including Medicaid or other third party insurance organizations. I authorize payment of those benefits to Maple Star Nevada. I understand that I am financially responsible for any portion of the services not covered by third-party benefits.

In accordance with existing law, the nature and purpose of the proposed evaluation and psychotherapy and other treatment methods, including the alternative of no therapy and risks of therapy have been discussed and explained to me, and my parent/legal guardian if I am 17 years of age or younger. I acknowledge that I have been given the opportunity to ask any questions about this form and its contents, and that I understand the provisions.

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If client is a minor, do they have a legal guardian or is there a joint legal custody arrangement? ☐ Yes ☐ No
If yes, the guardian or both parents must sign the consent before the assessment and any services are started.

Legal Guardian name: _____
-or-
Name(s) of parents with legal custody: _____

If a client is an adult, do they have a legal guardian? ☐ Yes ☐ No
If yes, the legal guardian must sign the consent before the assessment and any services are started.

I certify that I have read, understand, and agree to the above collection of information and have received a copy. (A copy of this document is to be given to the client or to his/her agent or Responsible Party.)

_____	_____
Client Signature	Date
_____	_____
Parent/Guardian Signature (where applicable)	Date
_____	_____
Parent/Guardian Signature (where applicable)	Date
_____	_____
Witness/Maple Star Nevada Representative Signature	Date

For children who receive PSR services: Consent to Transport/Pick-up (If Applicable)

_____By initialing here, I give my permission for my child or self to be transported by Maple Star staff to and from *school, special events, team meetings, etc.,* as it pertains to therapeutic services. I understand there are risks inherent in this situation (traffic delays, accidents, etc.) and I accept that risk.

_____By initialing here, I give my permission to _____ (name of school) to release my child to the care of Maple Star staff for the purpose of therapeutic services.