Judson Center HEALTH

Consent for Treatment

I understand that the Judson Center Family Health Clinic (JCFHC) offers integrated medical and behavioral health services. I understand Behavioral Health Specialists (BHS) will be working with Primary Care Providers (PCP) to best meet my healthcare needs. PCP and medical staff are provided through MedNetOne Health Solutions (MNOHS). Behavioral health staff are provided through Judson Center.

Judson Center staff and MNOHS staff will work together as needed. This is to provide whole person care. They will share written and verbal information about my health. They will be able to access my health records as needed. This is to be able to best coordinate my care and meet my overall needs. This information is confidential. I give permission to share health information, including:

- Psychiatric information
- Alcohol and drug abuse information
- HIV information

I give consent to receive care from the PCP and BHS as recommended and agreed to by me. This has been explained to me by my healthcare team. I understand I can stop receiving services at any time. I can also decide if I would like to receive services at any time.

Services/treatment that may be provided to me have been explained. This includes risks and benefits of care. I understand that treatment for substance abuse for minors does not require permission from my parents.

The JCFHC office is open on weekdays with the following hours:

- Monday through Thursday 8:30am to 8:00pm and Fridays 8:30am to 5:00pm
- For behavioral health emergencies I have been told to follow the crisis plan outlined in my Individual Plan of Service.

To contact the JCFHC, call (586) 573-1810. The JCFHC may need to provide information to others. Information may be shared without patient permission for the following reasons:

- Delivery of necessary medical or behavioral health services
- Patient may be a danger to self or others
- Suspected child abuse or neglect
- To receive payment from my insurance company or Community Mental Health
- Court order for patient records to be released

This consent is active for one year after the date it is signed. Services provided within this time will be covered by this consent as outlined above. *Please print.*

_____ _____ _____

Patient name *Date of birth* *Signature of patient or legal representative* *Date of birth*

Relationship to patient: ____Self ____Parent ____Guardian ____Authorized Representative

_____ _____

Signature of witness *Date*