Great Lakes Center for Autism Treatment and Research
an roi program

# General Consent for Treatment

CLIENT NAME:_____

LAST FIRST MIDDLE

ADDRESS:_____

PHONE: (  )_____BIRTHDATE_____CASE #_____

**1.** I hereby consent to the performance of routine evaluation and treatment, or other related services for the above named patient, including medical, psychiatric, psychological and educational services as considered necessary in the judgment of the professional staff at The Great Lakes Center for Autism Treatment and Research. I understand that unless otherwise stated, this consent shall remain in effect for a period of not to exceed **18 months.**

**2.** Information collected regarding the above named patient is kept private and confidential within The Great Lakes Center for Autism Treatment and Research. Information regarding the above named patient and care will only be shared with other individuals, agencies or organizations with my written permission. I have been informed and understand that there are some circumstances in which confidentiality may not be maintained and information may be shared with others without my written permission. Such circumstances include but are not limited to:

- Suspicion or report of child abuse or neglect
- Suspicion or report of danger to the patient or others
- Information is court-ordered
- Laws require The Great Lakes Center for Autism Treatment and Research to release medical information related to certain disabilities that are considered an interest to public health
- Review by governmental oversight or accreditation agencies (e.g., audits, inspections, license renewals)

**3.** I hereby authorize the release of medical records on the above named patient to any insurance companies or third party payers that may authorize coverage or payment for services rendered to or on behalf of the above named patient. Such records may include privileged information.

**4.** I understand that professionals, potential clients, staff, and other interested parties will occasionally be coming through Great Lakes Center for Autism Treatment and Research to see the program, setting, and children at which time my child will be observed in this environment.

**5.** I understand I am responsible for any co-payments, deductibles and/or outstanding bills not covered by my insurance or third party payers. I agree to pay at time of service or delivery of bill, unless other prior arrangements are made.

**6.** I have read and understand the Consent for Treatment form. I voluntarily and knowingly sign this consent form fully aware of its content.

_____

Parent/Guardian Signature Date

_____

Witness Date