Lighthouse Child & Family Services

School Linked Mental Health Consent Form

Client Name: _____ **DOB:** _____

Parent(s) Name: _____

Address: _____

Home Phone: _____ **Cell Phone:** _____

Emergency Contact: _____

Records Release: I hereby authorize the release of any information, including medical and billing information, by Lighthouse Child & Family Services (LCFS) to my referring doctor, insurance company, contracted billing company with LCFS, the responsible party named above, and immediate family on behalf of myself and/or dependents. *Initial here* _____

Assignment of Benefits: I hereby authorize payment of Medical Benefits by my insurance company to LCFS for services rendered to myself and/or dependents. I understand it is my responsibility to notify LCFS if my insurance is no longer active. *Initial here* _____

Acknowledgement of Receipt of Notice of Privacy Practices: I have read, or had read to me, and offered a copy of Notice of Privacy Practices and have received a copy of Notice of Privacy Practices/Tennessen/MN Data Practices Act/HIPPA. *Initial here* _____

Consent for Services: I give consent for my minor child to receive therapeutic services in my presence or in my absence, at school or any other mutually agreed upon location. I give consent for my child's clinician to speak with school staff and other behavior health staff in order to best treat my child. *Initial here* _____

Physician Release:
Mental Health Professionals are required to attempt to coordinate services with primary care Physicians. Please indicate which option:
___ No physician at this time.
___ I do NOT authorize the release of information to/with a physician at this time.
___ I authorize the release and exchange of clinical and/or medical information with my physician.
Initial here _____

Consent for Consultation: The therapists at Lighthouse Child & Family Services, LLC meet regularly for clinical consultation. I am aware of this and give my consent for confidential clinical review of my case. *Initial here* _____

Consent to Share Data with DHS: If you are receiving services through a DHS certified or funded program, you authorize LCFS to share necessary data with DHS for reporting purposes. Initial here _____

Health Care and Advance Psychiatric Directives (18 years and older): Do you have a Health Care Directive or an Advance Psychiatric Directive? Yes____ No____ If no, are you interested in receiving information regarding either? Yes____ No____

Consent for Treatment: By signing below, you agree to all initialed items listed above and consent for treatment by Lighthouse Child & Family Services, LLC.

X_____ X_____
Signature of Client/Responsible Party Date

For reporting purposes only:
Race: ☐White ☐Black/African Amer. ☐Amer. Indian ☐Alaskan Native ☐Asian ☐Other _____
Ethnicity: ☐Latino/Hispanic ☐Somali ☐Hmong/Loation ☐African ☐Other
Spoken Language _____ Do you have a need for an interpreter? Yes/No