STATE OF NEVADA

Division of Child and Family Services

Children’s Mental Health Programs

General Consent Form

Consent for Evaluation and Treatment of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Full Name of Client

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Record #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Consent to Evaluate/Treat:

I voluntarily consent that my child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by DCFS mental health professional staff. The evaluation or treatment will be conducted by a DCFS mental health professional (i.e., a mental health practitioner, psychologist, a psychiatric nurse practitioner, a psychiatrist, or an unlicensed practitioner who is supervised by any of the licensed professionals listed). Treatment will be conducted within the boundaries of Nevada Revised Statutes for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling professionals.

I understand that following the evaluation and/or treatment, complete and accurate information will be provided to me concerning each of the following areas, after which I will be asked to sign an informed consent if I want DCFS to provide mental health treatment services to my child:

* 1. The outcome of the evaluation and the benefits of the proposed treatment
	2. Alternative treatment modes and services
	3. The manner in which treatment will be administered
	4. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
	5. Probable consequences of not receiving treatment
1. Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me and my child, as well as the referring professional (if there is one), to understand the nature and cause of any difficulties affecting my child’s daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.
2. Service Charges: Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. DCFS is a Medicaid provider and,

I understand if my child is Medicaid eligible, fees for services will be submitted to Medicaid for reimbursement on my child’s behalf. If my child is not eligible for Medicaid, funding alternatives will be discussed with me but I understand I am ultimately responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

1. Confidentiality, Harm, and Inquiry: Information from my child’s evaluation and/or treatment is contained in a confidential medical record at DCFS. I provide my consent to DCFS to use this information for the purpose of continuity of my child’s care. Per Nevada Revised Statutes, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to him or herself or others; 2) if child maltreatment is suspected; or 3) if a court order is issued to obtain records.

1. Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating DCFS mental health professional.
2. Expiration of Consent: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legally responsible person for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of child) and have the right to consent for the evaluation and treatment of this child. I understand that I have the right to ask questions of my child’s assigned mental health professional about the above information at any time.

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Signature of Legally Responsible Person Date

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Signature of DCFS Witness Date