Mental Health Services
Informed Consent: Client & Parent

The School Based Clinic in your (or your teen's) school offers mental health counseling as one of its services. Our therapists are fully licensed by the State of Minnesota or are working towards State of Minnesota licensure. University students in Professional Mental Health graduate programs may also provide services at the School Based Clinic. As of July 2023, minors 16 years or older may consent for mental health treatment without parent consent.

Mental health therapy (also known as talk therapy) is an approach for assessing and treating mental health concerns. There are a variety of beneficial techniques that can be utilized to deal with the concerns that bring people to therapy. These services require your participation and cooperation. During therapy, you (and/or your teen) may be asked by the therapist to participate in a diagnostic assessment session and to assist in developing treatment goals and a plan for therapy.

Our therapists will do their best to make sure you (or your teen) will have a beneficial experience. However, therapy remains an inexact science and no guarantees can be made regarding the results. There are alternatives to counseling and therapy for addressing mental health issues. This includes consulting with your primary care physician for medical options or consulting with a spiritual leader in your community for spiritual options. You may also choose not to seek any treatment. This option may increase the risk of the current mental health issues becoming more difficult to cope with.

This consent contains important information about our mental health practices. Once this consent form is signed it will constitute an agreement between you (and/or your teen), the therapist, and the School Based Clinics.

Client Registration

Client First Name:_____ **Middle:**_____ **Last:**_____
Date of Birth: _____
***Sex at birth:** ❑ Female ❑ Male ❑ Intersex ***Gender identity:** ❑ Female ❑ Male ❑ Gender non-binary
***Pronouns:** ❑ She/her ❑ He/him ❑ They/them ❑ Other:_____

***Address:** _____ ***City:** _____ **Zip:** _____

***Language(s) spoken at home:** _____

***Race(s):** ❑ American Indian ❑ Asian ❑ Black ❑ Hispanic/Latino ❑ White ❑ Multi-racial

***Ethnicity:** ❑ Hispanic/Latino ❑ Hmong ❑ Non-Hispanic/Latino ❑ Somali ❑ Other African ❑ Other:_____

***Student phone:** _____ ❑ Cell ❑ Other ***Okay to text?** ❑ Yes ❑ No **Student email:**
_____

***School:** ❑ Camden ❑ Edison ❑ FAIR ❑ Longfellow ❑ Roosevelt
❑ South ❑ Southwest ❑ Washburn ❑ Wellstone ❑ Other: _____

Current Clinic: _____ **Current Doctor:** _____

Parent/Guardian Information

Name(s): _____ **Phone:** _____ ❑ Cell ❑ Home ❑ Work
❑ Parent ❑ Guardian ❑ Relative_____ **Email:** _____

Name(s): _____ **Phone:** _____ ❑ Cell ❑ Home ❑ Work
❑ Parent ❑ Guardian ❑ Relative_____ **Email:** _____

Limits of Confidentiality

As a rule, the therapist will keep the information shared in therapy sessions confidential unless there is written consent signed by you or in some cases, your teen, to disclose certain information. There are, however, exceptions to this rule that are important for you or your teen to understand before personal information is shared in a therapy session. In some situations, therapists may be required by law or the guidelines of their profession to disclose information whether they have permission.

Confidentiality cannot be maintained when:

- The client tells the therapist that they plan to cause serious harm or death to themselves.
- The client tells the therapist they plan to cause serious harm or death to someone else.
- The client is doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person.
- The client tells the therapist they are currently being abused - physically, sexually, or emotionally, or has been within the past three years.

Communicating with parent(s) or guardian(s)

Except for situations such as those mentioned above, therapists will not tell specific things clients share in private therapy sessions unless the client gives consent.

Release and Consent to Communicate, Consult and Coordinate Care with School Staff

The therapist may need to work with members of the school staff to coordinate services and provide the best quality care for you (or your teen). For example, you (your teen) may qualify for school accommodations on a 504 plan with a mental health diagnosis. **This may involve sharing limited but necessary information.**

Release and Consent to Audio/Video Recording

To improve our services, we provide supervision and training using video and audio recording. This method allows for the direct feedback and supervision of the therapist and improves the quality of service the client receives. Professionals involved in this supervision and training may include supervisors, colleagues and graduate school professors. Permission from clients will be obtained prior to any recording. All audio and video recordings are destroyed after they are no longer needed for the purposes stated above.

Release and Consent to Participate in Evaluation

The SBC may provide service information to Washburn Center for Children for the purpose of reporting outcome measures to the Minnesota Department of Human Services and MPS for grant requirements- this data does not identify individual clients. The SBC may also provide program data to Hennepin County including chart audits for quality assurance and grant requirement purposes.

Billing/Payment Policy

SBC Mental health care can be provided regardless of health insurance. The clinics will bill insurance whenever possible to help cover the cost of services; co-pays and deductibles will only be charged to those with private insurance. After we receive insurance payment, the policy holder will receive an email invoice with a link to pay via a secure and private website (rectangle health).

We really appreciate any payments that you can make. We will never send your account to any outside collection agency and do not want your inability to pay to in any way impact the care your teen receives from the School Based Clinic. If you have any questions, please feel free to contact the School Based Clinic Manager at 612-668-5305.

Do you or your teen have health insurance? ❑ Yes ❑ No

Name of Insurance: _____

Insurance Provider/Payer ID: _____ Group Number: _____ **Phone:_____**

Policy Holder Name: _____ Policy Holder: DOB: _____ Policy Holder SSN:_____

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I hereby authorize The Minneapolis Health Department School Based Clinics to release all billing and medical information regarding my diagnosis, treatment, and substance abuse if applicable to any third-party payer, when such information is requested for payment utilization review or coverage determination purposes.

❑ I consent to receive invoices via encrypted email. Email: _____

Summary of Consent

By signing this form, you agree that:

- You have read and understood the services of the Minneapolis School Based Clinic mental health program.
- You give permission to receive mental health services offered by Minneapolis School Based Clinics.
- You give permission to release information as explained to the parties named in the release and consent to communicate, consult and coordinate care with school staff
- You give permission to release information to the parties named as explained in the release and consent to participate in evaluation section.
- Your authorization will remain in effect unless changed by you in writing or when you/your teen end SBC MH services.
- I understand this consent can be canceled at any time by writing a note of cancellation and giving it to my therapist or clinic management at Minneapolissbc@minneapolismn.gov. When authorization is given, it is effective from that day forward.

My signature below means that I understand and agree with all the points above.

_____ _____ _____

Client Signature Print Name Date

_____ _____ _____

Parent\Guardian Signature Print Name Date

I, the practitioner/professional providing clinical services, have discussed the issues above with the client and/or parent or guardian of a minor client and answered their questions. The client and/or their parent/guardian provided informed consent to the above mental health services.

*SBC Provider Signature*_____ *Print Name*_____ *Date*_____

For Office Use Only

Type of consent	
Parent/guardian consent	☐ Yes
Minor Mental Health	☐ Client signed- Confidential – do not bill
	☐ Client signed parent/guardian involved ok to bill