UNITY HEALING CENTER
INFORMED CONSENT FOR TREATMENT

I hereby voluntarily apply for and consent for _____to receive **ADOLESCENT RESIDENTIAL TREATMENT SERVICES** provided by Unity Healing Center. This consent applies to my child, or my ward. Because my child has the right to refuse services at any time, I understand and agree that continued participation implies voluntary informed consent. In this Consent, the terms "child" and "resident" are used interchangeably.

LIMITATIONS OF SERVICES

I understand that Unity Healing Center's (UHC) services consist complete medical assessment and treatment as indicated, psychological evaluation, assessment, consultation, and therapeutic interventions and recreational, cultural and educational assessments and interventions. I understand that evaluation and assessment services may also include the use of psychological and neuropsychological tests if indicated. I understand that intervention services may include counseling (group and individual therapy). The provision of services and continuing care is not based on the ability to pay; services are based on need for care.

I understand that Unity Healing Center is not warranting a cure or offering any guarantee of results or improvement of any condition.

ASSUMPTION OF RISKS AND BENEFITS

Potential benefits of treatment include clarifying diagnosis and/or reducing medical, cultural, educational, emotional, behavioral, or relationship issues. I understand that alternative procedures available to my child or ward include: services provided by another residential facility, psychiatrist, or mental health professional or no treatment at all.

LIMITS OF CONFIDENTIALITY

I understand and agree that all disclosures and communications are considered Protected Health Information (PHI) except to the extent that I authorize a release of information, or under certain other conditions listed below. I understand that Protected Health Information (PHI) may be released without my consent or authorization in the following circumstances recognized by Unity Healing Center policy, CFR 42, Part 2 Confidentiality of Alcohol and Drug Abuse Resident Records, The Privacy Act and the IHS Notice of Privacy Practices as identified in the new HIPAA regulations:

Child Abuse: Any UHC staff member, contractor, or volunteer who has a reasonable suspicion or knowledge of or has been made aware of an incident of child abuse and/or neglect that may have occurred before, during, or after treatment was received at UHC, will make a report to the appropriate investigative agency.

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Health Oversight: If a complaint is filed against UHC to Indian Health Services on behalf of my child Indian Health Service has the authority to view all confidential mental health information from UHC records relevant to that complaint.

Judicial or Administrative Proceedings: If your child or ward is involved in a court proceeding and a request is made for information about your child or ward's diagnosis or treatment and the records thereof, such information is privileged under federal law, and UHC will not release information without the written authorization from you or your legal representative, or a subpoena of which you and your child or ward have been properly notified and you have failed to inform UHC that you are opposing the subpoena or a court order. The privilege does not apply when your child or ward is being evaluated for a third party or where the evaluation is court ordered. You and your child or ward will be informed in advance if this is the case.

Serious Threat to Health or Safety: When your child or ward present a clear and immediate probability of physical harm to him/herself, to other individuals, or to society, UHC may communicate relevant information concerning the potential harm to the victim, appropriate family member, and law enforcement or other appropriate authorities.

I hold Unity Healing Center harmless for releasing information under any of the above conditions.

STATEMENT OF UNDERSTANDING AND RECEIPT OF NOTICE

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will expire automatically as follows. I understand that my consent for release of information will be considered valid for twelve (12) months following the date below. I acknowledge that I voluntarily consent to the preceding conditions and that this consent form is valid during any related claims. I certify that I have read this form or that it has been read and explained to me in terms that I understand. My questions have been answered to my satisfaction, all blank spaces on the form have been completed, and all statements of which I do not approve have been stricken. By signing this form, I understand and agree with the terms and conditions of this form.

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Resident Signature	Date
Parent or Guardian Signature	Date