# MINDCARE, LLC

## PARENT / LEGAL GUARDIAN CONSENT FOR BEHAVIORAL HEALTH SERVICES

Downtown Summerville, Georgia • 706-388-1189 • talk@mindcare.us • www.mindcare.us

### 1. CHILD INFORMATION

| | |
|---|---|
| Child's Legal Name: _____ | Date of Birth: _____ |
| School / Grade: _____ | Parent/Guardian Phone: _____ |

### 2. PARENT / LEGAL GUARDIAN

Name: _____ Relationship to Child: _____

I certify that I am legally authorized to consent to behavioral health services for this child. If requested, I will provide custody, guardianship, or other documentation establishing my authority.

### 3. CONSENT FOR SERVICES

I voluntarily authorize MindCare, LLC and its appropriately qualified professionals to provide behavioral health services to my child as clinically appropriate. Services may include:

☐ Individual counseling ☐ Family counseling ☐ Trauma-focused counseling ☐ CBT ☐ Play Therapy ☐ Art Therapy ☐ Small-group counseling ☐ Behavioral/emotional support ☐ Assessments ☐ ABA services, when applicable ☐ Other:

_____

Services may be provided at the MindCare office in downtown Summerville, at the child's school when arrangements have been made, or by telehealth when appropriate and permitted.

### 4. SCHOOL-BASED SERVICES & PARENTAL CONSENT

For school-based services, a signed parent/legal guardian consent must be received BEFORE MindCare initiates counseling services or contacts the student for the purpose of beginning services, unless an applicable law, court order, emergency exception, or other legally recognized circumstance applies.

When services occur at school, MindCare may communicate with appropriate school personnel as necessary for scheduling, access, safety, and service coordination. Confidential treatment information will not be routinely shared with school personnel without appropriate authorization or as otherwise permitted or required by law.

### 5. CONFIDENTIALITY

I understand that counseling information is generally confidential. Confidentiality has legal and professional limits, including situations involving suspected abuse or neglect, serious or imminent safety concerns, court orders, emergencies, or other disclosures required or permitted by law. A separate written authorization may be required to release protected health information to schools, DFCS, physicians, or other third parties.

### 6. GROUP, PLAY & ART THERAPY

I understand that small groups may include students with similar needs. MindCare will instruct participants to respect privacy, but MindCare cannot guarantee that another group participant will maintain confidentiality. Play therapy, art therapy, and other creative activities may be used as therapeutic interventions when clinically appropriate.

### 7. INSURANCE & PAYMENT

MindCare accepts Medicaid and most major private insurance plans for covered and approved services. Coverage, eligibility, authorization, medical necessity, and payer rules determine payment. Services not covered by a payer may require another approved payment arrangement. School-funded services may also be arranged when applicable.

### 8. EMERGENCIES

Counseling is not an emergency service. If a serious or immediate safety concern arises, MindCare may contact the parent/guardian, emergency services, crisis resources, or other appropriate persons/agencies as permitted or required by law. For an immediate emergency, call 911 or the appropriate crisis service.

### 9. ACKNOWLEDGMENT & CONSENT

By signing below, I confirm that I have read and understand this consent, have had an opportunity to ask questions, and have legal authority to consent. I understand that counseling outcomes cannot be guaranteed and that I may withdraw consent for future services by notifying MindCare in writing, subject to applicable law and payer/contract requirements.

Parent/Legal Guardian Printed Name: _____

Signature: _____ Date: _____

Second Parent/Guardian, if applicable: _____

Signature: _____ Date: _____

**Please return this completed form to MindCare before services begin.**