MILESTONES
CLINICAL & HEALTH RESOURCES
WWW.MILESTONESCLINIC.COM
a division of Stone Belt

550 S. Adams Street · Bloomington · Indiana · 47403 · (812) 333-6324
1531 13th Street · Columbus · Indiana · 47201 · (812) 376-6501

AUTHORIZATION/CONSENT FOR SERVICES

Milestones offers a variety of mental health services. Our psychiatric services are provided by Board Certified physicians, and our therapy services by licensed clinicians, or clinicians-in-training. Clinicians-in-training are under the direct supervision of approved and licensed mental health supervisors.

We are *required* to obtain your consent for treatment.

⇒ If you are a 2-parent unified family, only 1 parent needs to sign for consent.
⇒ If you have sole custody, only the sole custodial parent needs to give consent.
⇒ If you have joint custody/guardianship **BOTH** parents/guardians must give consent for treatment.

Please check any/all boxes below that apply to your family situation(s) and then complete the consent by signing below. This is a legal matter for both you and Milestones. *Please answer honestly.*

☐ 2 Parent, United Family; ☐ Single Parent Family; ☐ Step/Blended Family; ☐ Adoptive Family; ☐ Legally Separated; ☐ Sole Legal Custody; ☐ Temporary Sole Legal Custody; ☐ Joint Legal Custody; ☐ Temporary Joint Legal Custody; ☐ Other:_____

I/we _____ and _____ request, authorize and consent Milestones, its agents, employees, physicians, or practicum students to provide and perform psychiatric and counseling/therapy services, tests and other services, and prescribe medications as are considered advisable, to me **or** my dependent. I acknowledge and agree that no guarantee or assurance has been given to me as to the results that may be obtained by my consent to treatment.

Consent for Treatment of (dependent name):_____ DOB_____

Consenting Parent(s)/Guardian(s) Signatures:_____

OR

Adult consenting to treatment of Self:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

(You may refuse to sign the acknowledgement.)

Our Privacy Practices Notice & Patient Rights is also available on our website at www.milestonesclinic.org under Patient Forms.

I have received a copy of Milestones' Notice of Privacy Practices and Patient Rights.

Signature:_____ Date:_____

Office Use Only:

On _____(date) a good faith effort was made to obtain written acknowledgement of receipt of our NOTICE OF PRIVACY PRACTICES. We were unable to obtain acknowledgement for the following reason:
☐Patient/Guardian/Parent refused to sign ☐Other_____
(possible reasons: Language difficulty, communication barriers, emergency)
Staff Name & Signature:_____

MILESTONES PATIENT HANDBOOK: I have received a Milestones Patient Handbook, which includes Patient Rights, and I agree to review it. If I have any questions or concerns about any topics in the Handbook, I can discuss my concerns with my Mental Healthcare Provider. *(Handbooks are available at www.milestonesclinic.org or in the lobby)* ⇨ Initials:_____ Date:_____