

## 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](http://www.milestonesclinic.org) under Patient Forms.

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

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

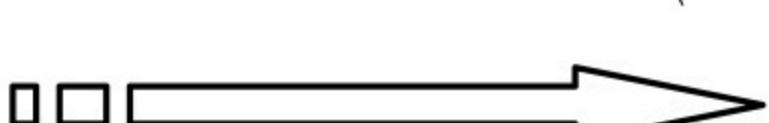
**Office Use Only:**

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](http://www.milestonesclinic.org) or in the lobby*)



Initials: \_\_\_\_\_ Date: \_\_\_\_\_