Youth Services of Glenview/Northbrook
Consent to Treatment

Client Name: Client Date of Birth:

Please read the following consent to treatment, initial to the left of each statement, and sign below:

_____ I have received and read Youth Services' treatment agreement, discussed any questions or concerns with agency staff, and consent for the above-indicated client to receive clinical services from the agency, and consent for the agency to utilize screeners and assessment tools, as outlined in the treatment agreement.

_____ I have received, read, and understand Youth Services' privacy practices, as outlined in the treatment agreement.

_____ I have received, read, and understand the risks of teletherapy as outlined in the treatment agreement, and understand the steps that agency staff and I will take to manage said risks. I have asked any outstanding questions I have about teletherapy, and consent to teletherapy services.

_____ I understand that I am giving written consent to my therapist/my child's therapist to use non-HIPAA-compliant videoconferencing and communication software/platforms for teletherapy sessions and communication when HIPAA-compliant software/platforms are not available or functioning properly and/or for other personal reasons I may have. I understand that my/my child's therapist and Youth Services of Glenview/Northbrook cannot be held liable for any potential breach of information.

_____ I have received, read, and understand Youth Services' practices to mitigate the spread of COVID-19 and other contagious illnesses, as outlined in the treatment agreement. I understand that agency policies related to masking, social distancing, and other mitigation strategies may change based on CDC guidance, and I agree to follow all agency policies.

_____ If I am using my insurance, I authorize the release of information necessary for Youth Services to process the insurance claim for the above-indicated client's services and authorize payment of insurance benefits to Youth Services. Furthermore, I agree to pay the cost of what my insurance does not cover. If I am not using insurance, I consent to pay the agreed-upon private pay fee (as listed on the client information and billing form).

_____ I understand that payment for services are to be made at the time of service unless prior financial arrangements have been made.

_____ I understand that I am financially responsible for all scheduled appointments unless a minimum of 24 hours' notice is given and that Youth Services reserves the right to charge for missed sessions and late cancellations.

_____ I have disclosed all the above-indicated client's allergies, food restrictions, and/or medical restrictions. *Please list here:*

_____

_____ I consent for the agency to provide emergency medical assistance to the above-indicated client, if necessary.

_____ I consent for agency staff or interns to transport the above-indicated client, if necessary and agreed upon with the client and parent/guardian.

Client or Parent/Guardian Signature	*Client or Parent/Guardian Printed Name*	*Date of Signature*