Behavioral Health Services OF ARKANSAS

Name:_____ **Date of Birth:**_____

1. Consent to Evaluate/Treat: I voluntarily consent that *my* child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Behavioral Health Services of Arkansas (BHSA), our collaborative community mental health agency. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. The manner in which treatment will be administered
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
   e. Probable consequences of not receiving treatment

   The evaluation or treatment will be conducted by a psychiatrist, a licensed therapist, and a registered nurse. Additional supportive services may be provided when prescribed or indicated by a school counselor, educational guidance counselor, mental health paraprofessional, or licensed psychological examiner.

2. Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to *my* child, as well as the referring professional, to understand the nature and cause of any difficulties affecting *my* child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation, estimating prognosis, and education. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. Confidentiality, Harm, and Inquiry: Information from *my* child's evaluation and/or treatment is contained in a confidential electronic medical record maintained by BHSA. Per Arkansas mental health law, information provided will be kept confidential with the following exceptions: 1) if *my* child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

4. Right to Withdraw Consent: I have the right to withdraw *my* consent for evaluation and/or treatment of *my* child at any time by providing a written request to the treating clinician employed by BHSA.

5. Expiration of Consent: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_____ _____
Signature of legal guardian for minor under age 18 Date

_____ _____
Signature of witness Date