Case No:_________________

CLIENT RIGHTS/RESPONSIBILITIES AND CONSENT TO TREATMENT AND DIAGNOTIC SERCIVES

Client: ____

I understand that the services my dependent or I will receive at Family Counseling and Children's Services are based on currently accepted practice in the fields of mental health. I also understand that the outcome of treatment cannot be guaranteed and that services continue only with my voluntary consent.

The purpose of Family Counseling and Children's Services of Lenawee County is to help me with personal, marital or family issues/problems and are delivered by professionally trained social workers, psychologists, and psychiatrists. I am aware that Family Counseling and Children's Services of Lenawee County is a private, non-profit, non-sectarian counseling agency serving any resident of Lenawee County on an ability to pay basis. I understand that no one will be denied services based on age, race, color, religion, sex, or handicap.

Also, I recognize that in order for Family counseling and Children's Services to provide care to me or my dependent, I may be asked to consult with a psychiatrist at Family Counseling and Children's Services when this is considered necessary by other clinical staff members. I, too, may ask to consult with a psychiatrist on staff at Family Counseling and Children's Services, if I consider this necessary.

I understand that Family Counseling and Children's Services reserves the right to refuse services to persons engaging in dangerous, unpleasant behavior, or substance abuse and such persons may be asked to leave the agency. I am aware that both staff and clients are expected to use courtesy in their relationships.

-continued on back-

My signature below acknowledges that I am voluntarily authorizing diagnostic and treatment services at Family Counseling and Children's Services for myself or my dependent. I recognize that I may refuse any aspect of treatment. I also accept that such a refusal may, in some instances, result in termination of services by Family Counseling and Children's Services.

I have read this consent, have received copies of this consent and a statement of Patient Rights and agree with the policies of Family Counseling and Children' Services. I herby assert that I have the legal right to enter my self, child and / or dependent into the before mentioned counseling agreement.

DATE	SIGNATURE OF CLIENT/PARENT/GUARDIAN	FCCS INIT.
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