HMSA HEALTH MANAGEMENT SYSTEMS OF AMERICA

HELPING PEOPLE | INSPIRING SOLUTIONS

Student Assistance Program (SAP)

SAP Registration and Consent to Treat a Minor

HMSA and some state laws require the consent of a parent or legal guardian for a client under the age of 18 to receive mental health services from a non-physician, except for the following circumstances:

1) When the student is or has been married;
2) When the student serves in the armed forces;
3) When the student is legally emancipated.

It is the stance of HMSA that unless the above exceptions apply, you, as the parent or legal guardian of a minor, and all required parties must complete, sign and return this consent form prior to your child being eligible for services. Completion of this form allows your child in grades 7 through 12 to participate in this valued service and its benefits made available by your school. This form must be returned to Canton Middle/High School, 76 Simonds Avenue:

Grades 7 - 8
CMS Office
Attn: Amy Brintle

Grades 9 - 12
CHS School Counseling Office
Attn: Ann Beman

I, _____(print name of guardian) am the parent/legal guardian of _____(print name of student), a minor whose birthday is ____/____/_____.

I authorize HMSA to provide services, as it falls within the scope of the SAP, to my son/daughter/dependent. I understand that my child can benefit most from having a confidential relationship with their assigned certified life coach and licensed mental health counselor, and therefore agree to limited communication with the assigned certified life coaches and licensed mental health counselors.

I authorize HMSA to release information between the SAP counselor and parent in the event that the child requires a higher level of care that is outside the scope of the Student Assistance Program.

Initials: Student _____Parent/Guardian_____Date_____

In the event there is a need/recommendation for clinical services outside the scope of the SAP or if there is an emergency (medical/psychiatric), the parent/guardian below will be notified by telephone.

In the event there is a need/recommendation for clinical services outside the scope of the SAP, the parent(s)/guardian will be notified for need for continued care through a provider on their insurance or local community resources.

I further understand that, once my child turns 18, my consent for treatment will no longer be required. **This consent will remain valid while the student remains actively enrolled within the school district, unless otherwise requested by parent/guardian or eligibility status changes.**

By signing this, I acknowledge that I have read and understand this consent, and that I have been able to call Health Management Systems of America 888-387-1540 to have any questions answered before signing.

_____ _____

Signature of Parent/Guardian Date

Parent/Guardian's Phone Number(s):

Home: _____ Work: _____ ext _____

Cell: _____

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Consent to Treatment Student Name: _____

Confidentiality: The personal information you share with your certified life coach and licensed mental health counselor is confidential in accordance with Individual State Privileged Communication laws, professional ethical codes, and federal privacy regulations. Outside of the exceptions listed below, no information is released to parties, outside HMSA without your expressed written consent. Your certified life coaches and licensed mental health counselors may share information with other HMSA professionals for the purpose of coordinating care, which may become part of your record. Your initials here show your understanding of and consent to the above communication:

The exceptions to the rule of confidentiality are:

a) If you, the student, are clearly likely to physically harm to yourself or another person in the near future, it is your certified life coaches' and licensed mental health counselor's duty to take steps to protect your safety and the safety of others.

b) If you, the student, share information about currently occurring abuse or neglect of a child or dependent adult, state law requires that your certified life coach and licensed mental health counselor report the information to the Department of Social Services.

c) If ordered to do so by a judge as part of judicial proceedings, the Student Assistance Program may release information contained in your electronic record.

Initials: Student _____ Parent/Guardian_____ Date_____

Your Rights: As with licensed mental health counselors, psychologists, social workers, certified life coaches and other mental health providers we uphold ethical and professional standards. It is also important to know that you have the right to discontinue services at any time or any reason. We request that you let your certified life coach and licensed mental health counselor know of your intentions, so that other services options may be offered and suggested. Please let your certified life coach and licensed mental health counselor know if you have any questions about the above information.

My signature below indicates that I have read and understand the above information, and I consent to the service(s) offered and provided by Health Management Systems of America and its staff/affiliates. I understand that my treatment with the Student Assistance Program center is voluntary and that I may discontinue treatment at any time and for any reason.

_____

Printed Name of Student

_____ _____

Student Signature Date

_____

Printed Name of Parent/Guardian

_____ _____

Signature of Parent/Guardian Date