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Consent to Treatment

_____
Client Name (Printed)

I give my consent to MEDA, Inc. to provide group support services for my child or me. I understand that my involvement in the group is confidential. Information may not be released without my written consent except under the following conditions:

1. Concerns of actual or suspected child abuse are required by law to be reported to the Department of Social Services.
2. In situations of potential harm to oneself.
3. In situations of potential harm to others it is required by law to observe the duty to warn.
4. In instances of court subpoena records.

- I understand that MEDA requires all clients to be monitored by their primary care physician.
- If I experience a medical or psychiatric emergency during program hours, I agree to go to the local emergency room via ambulance.
- I understand this group is not intended to be a primary source of treatment, but a useful adjunct to therapy – not a substitute. While group members are assured of confidentiality, certain limitations apply when you or someone else is a risk to themselves or others. The undersigned agrees that neither the client or legal representative nor any minor participant named below, nor the legal representative of said minor participant will make any claim whatsoever against MEDA, its officers, directors, or group leaders from any liability as a result of any such circumstance. By signing this statement, I acknowledge and understand these terms.

I give my consent to participate in treatment and have read and understand the above guidelines.

_____ Date: _____
Client or Legal Guardian (Printed)

_____ Date: _____
Client or Legal Guardian (Signature)

Payment Contract

I agree to the following terms pertaining to my participation in a support group with MEDA:

- I will participate in and pay $150.00 for a teen assessment.
- I will participate in and pay $100.00 for a mandatory group assessment.
- I agree to pay $240.00 for each 8-week group session. This payment is required prior to the start of group.
- If I decide after the intake appointment not to attend the group, my assessment fee is NOT refundable.
- There is a $25.00 fee for all returned checks.

_____ Date: _____
Client or Legal Guardian (Printed)

_____ Date: _____
Client or Legal Guardian (Signature)

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Consent for the Release and Request of Information to Outpatient Providers

Client Name: _____ Date of Birth: _____

I, _____ hereby authorize MEDA staff to release to and request from:

Name of Physician: _____
Physician Phone Number: _____
Physician Email Address: _____ _____

Name of Therapist: _____
Therapist Phone Number: _____
Therapist Email Address: _____

Name of Dietician: _____
Dietician Phone Number: _____
Dietician Email Address: _____

Other Support: _____

Information regarding my medical status- This information is needed for the purpose of my participation in MEDA's group services. I understand that MEDA abides by federal confidentiality regulations (42 CFR Part 2) published July 1, 1975 which protects the confidentiality of my record and that information contained in my record cannot be disclosed without consent unless otherwise provided for in the regulations. I understand that this directive is subject to revocation at any time upon written request.
I herewith release and hold harmless the Multi-service Eating Disorder Association, Inc., and any of it's officers, board members, employees, directors, group leaders, or volunteers from any liability for the release of any information provided in accordance with this directive.

_____ Date: _____
Client or Guardian Signature

_____ Date: _____
Witness