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Consent to Treatment

- 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, as recommended by their physician.
- I understand and agree to maintain safety.
    1. If I experience a medical emergency during program hours, I agree to go to the local emergency room via ambulance.
    2. If I experience a psychiatric emergency during program hours, I agree to go to the local emergency room via ambulance for evaluation.
- I understand this group is not intended to be a primary source of treatment. This group is viewed as a useful adjunct to therapy and should not be seen as 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 s/he nor her/his 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.
(X)_____ Date: _____
Client or Legal Guardian

(X)_____ Date: _____
Witness

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Payment Contract

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

- I will participate in and pay $100.00 (cash, check, or debit/credit) for a mandatory group intake session (if I have not already).
- I agree to pay $240.00 (cash or check) 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 $100.00 intake fee is NOT refundable.
- There is a $25.00 fee for all returned checks.

(X)_____ Date: _____
Client or Legal Guardian

(X)_____ Date: _____
Witness

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Individual Guidelines

I understand and agree to the following individual guidelines. I understand that non-compliance with any of the following guidelines may result in termination of services:

- Medically stable
- No active alcohol or substance abuse
- No current suicide behavior or intent
- Offer complete emergency contact information
- Consent to release and request of information from individual therapist and physician
- Sign disclaimer statement at each group session
- Show a willingness to collaborate with treatment and challenge fears of recovery

(X)_____ Date:_____
Client

(X)_____ Date:_____
Parent / Legal Guardian

(X)_____ Date:_____
Witness

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Group Guidelines

I understand and agree to the following group guidelines. I understand that non-compliance with any of the following guidelines may result in termination of services.

- Remember to be on time and to leave on time
- Confidentiality – what is said in group, stays in group
- Do not state weight or size
- DO NOT bring food to group, non-alcoholic drinks are permitted
- Be as honest and sincere as possible
- Listen to others
- Welcome differences
- Ask for what you need
- You have the right to say NO and be silent and the right to say YES and take time to talk
- We encourage you to utilize others for support. If you choose to share time outside of group with other members, we ask that you remember it is based on support for recovery.

I have read and agree to the above group guidelines.

(X)_____ Date:_____
Client

(X)_____ Date:_____
Parent / Legal Guardian

(X)_____ Date:_____
Witness

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Consent for the Release and Request of Information for Physician

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:_____

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.

(X)_____ Date:_____
Client or Guardian Signature

(X)_____ Date: _____
Witness

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Consent for the Release and Request of Information for Individual Therapist

Client Name:_____ Date of Birth:_____

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

Name of Therapist:_____

Therapist Phone Number: _____

Therapist Email Address:_____

Information regarding individual psychotherapy. 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.

(X)_____Date:_____
Client or Guardian Signature

(X)_____ Date: _____
Witness

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Parent/Guardian Group Attendance Permission Form

I _____, give my permission for
Parent/Guardian

_____to attend MEDA'S support group
Minor Client

on a weekly basis. I understand and agree to the following:

This group is not intended to be a primary source of treatment. This group is run by recovered individuals, not licensed mental health providers. This group is viewed as a useful adjunct to therapy and should not be seen as 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 s/he nor her/his 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 by virtue of any event or circumstance occurring as a result of participating in MEDA's group and forever releases and fully discharges MEDA, its officers, directors and group leaders from any liability as a result of any such circumstance. By signing this statement, you acknowledge and understand these terms.

(X)_____ Date_____
Parent/Guardian Signature

(X) _____ Date _____
Witness

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Individual Guidelines

I understand and agree to the following individual guidelines. I understand that non-compliance with any of the following guidelines may result in termination of services.

- Medically stable
- No active alcohol or substance abuse
- No current suicide behavior or intent
- Offer complete emergency contact information
- Consent to release and request of information from individual therapist and physician
- Sign disclaimer statement at each group session
- Show a willingness to collaborate with treatment and challenge fears of recovery

Group Guidelines

- Remember to be on time and to leave on time
- Confidentiality-what is said in group stays in group
- Do not state your weight or size
- Do NOT bring food to groups (non-alcoholic drinks are permitted)
- Be as honest and sincere as you can
- Listen to each other
- Welcome differences
- Ask for what you need
- You have the right to say NO and be silent and the right to say YES and take time to talk
- We encourage you to utilize others for support. If you choose to share time outside of group with other members, we ask that you remember it is based on support for recovery.