MACOMB COUNTY COMMUNITY MENTAL HEALTH
SPECIAL CONSENT FOR BEHAVIOR TREATMENT PLAN

PROVIDER: _____CASE NO: _____

The undersigned hereby grants consent for the following named consumer/self, _____,
to participate in the authorized Behavior Treatment plan dated _____. This consent encompasses only the following types of techniques: _____
_____
_____
_____

As a consumer, parent, guardian or designated patient advocate, I understand the rationale for the procedures, risks, consequences, and other relevant factors. I have been provided with an explanation of the program procedures, a description of the potential risks and discomforts that might be experienced, a description of the potential benefits of the program, and answers to inquiries concerning the program and alternative programs, if any. I realize that I may withdraw consent and discontinue treatment at any time without prejudice, and that I may require other treatment forms. I understand that I have the right to request a review of the written Individual Plan of Service, including the right to request that person-centered planning be re-convened, in order to revisit this behavior treatment plan I also realize the Behavior Treatment Plan Review Committee will receive periodic updates on this program. At this time, I give consent for this program to be implemented.

The behavior treatment plan which will be implemented by a Directly-Operated or Contract provider of MCCMH has been explained to my satisfaction by _____ on _____
(MCCMH staff or contract agent) (date)

This consent expires on _____ (not to exceed one year from the date of authorization), or on termination of services, or whenever interim circumstances or changes in the Behavior Treatment Plan substantially affect the risks or other consequences or benefits reasonably to be expected.

WITNESS'S SIGNATURE	**date**	**CONSUMER'S SIGNATURE**	**date**
WITNESS'S SIGNATURE (if applicable)	**date**	**PARENT'S SIGNATURE (if applicable)**	**date**
WITNESS'S SIGNATURE (if applicable)	**date**	**GUARDIAN'S SIGNATURE (if applicable)**	**date**
WITNESS'S SIGNATURE (if applicable)	**date**	**PATIENT ADVOCATE SIGNATURE (if applicable)**	**date**

NOTES:_____
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