
Client Name

BEHAVIORAL HEALTH INFORMED CONSENT

In the interest of assuring that you are informed of the conditions of involvement with our services, please be informed the following:

1. PARTICIPATION IN SERVICES

Treatment is most effective when there are occasional discussions about your progress and counseling experience. You will develop a treatment plan collaboratively with your counselor, and participate in periodic reviews of your treatment and progress,

If you feel your treatment isn't helping you, please inform your counselor, so that your treatment plan can be revised to most effectively meet your needs.

Your time is reserved for you. If you must cancel, please provide a courtesy **24** hour notice. Individual sessions generally last fifty to sixty minutes. If you do not call to cancel your appointment by **8AM** on the day of your appointment and fail to show, this will incur a missed appointment fee of up to **\$15** for each no show.

If you are more than ten minutes late for a session, this could be considered a "no show". If you arrive late, your appointment will still end at the designated time.

A returned check fee of **\$25** will be applied to your bill for all returned checks.

If you do not have insurance or your Medi-Cal should lapse for any reason, you will be required to pay the Uniform Method of Determining Ability to Pay (UMDAP) calculated by your income. You can set up monthly payments with the front office staff.

After 3 repeated absences/failure to participate in services may result in discontinuation of services.

If you are not scheduling sessions and/or arriving for sessions for a continuous period, we will assume you are voluntarily terminating services with us, and your client file will be closed. Should your file be closed, you will be eligible to participate in another intake and assessment process, and this would be considered a new admission.

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2. DIAGNOSIS

If you are eligible for services through Sierra County Behavioral Health, you meet criteria for a qualifying diagnosis. We are required to give a diagnosis to document that you meet criteria for services. Your clinician will discuss your diagnosis with you, and how you meet criteria for the diagnosis.

Note a diagnosis is a representation of presenting issues, and is something that is experienced on a continuum. You may meet criteria for a diagnosis during one stage of your life, and not meet criteria at another. It is estimated that a majority of people will meet criteria for a mental health diagnosis at some point in their lives.

3. LIMITS OF CONFIDENTIALITY

- a. In accordance with State and Federal laws, Behavioral Health staff are legally obligated to make a report to the appropriate entities if they have reason to suspect the following.
 - ⇒ A **child** is in danger of abuse or neglect.
 - ⇒ An **elder** (65 years or older) is in danger of being abused or neglected. (Note, for elders, financial abuse is considered a form of abuse).
 - ⇒ Someone appears to be in **imminent danger** of harming themselves or others.
- b. Your mental health record can be subject to a **legal subpoena** in a legal proceeding.
- c. If you are paying for services through your **insurance company**, we are obligated to let your insurance company know your diagnosis and, in some cases, details of your treatment, as a condition of insurance reimbursement.

4. SOCIAL CONTACT WITH MENTAL HEALTH STAFF

Note it is against professional Codes of Ethics to engage in social relationships with clients or former clients. If your counselor or another mental health employee sees you in public, you are welcome to initiate a conversation. They may avoid initiating a conversation with you, in order to protect your privacy.

If you wish to discuss your case, you are encouraged to contact your counselor at the office during regular business hours. We avoid discussing confidential matters in public.

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5. GRIEVANCES

You may file a grievance if you are dissatisfied with our service. The information described below regarding filing grievances is posted in our waiting room.

You may call any of the following entities to register a complaint:

- **Lea Salas Assistant Director** of Human Services 530-993-6700.
- **The Patient Rights Advocate** at 530-886-5419 or 1-800-488-4308 ext 5419.

You may use provided addressed envelopes and mail your concern(s) to any of the entities listed above, C/O P.O. Box 1019, Loyalton, CA 96118. Addressed envelopes are available for you in the waiting room of the mental health department.

- ❖ **The Patient Rights Advocate** can assist you with registering a formal grievance.
- ❖ Your complaint or grievance will be **confidential**.
- ❖ **You will not be discriminated against** or penalized for filing a grievance.
- ❖ You will receive **notification** that we received your grievance, provided we have your contact information.
- ❖ You will receive a **written decision** on your grievance within 60 calendar days after your grievance has been received.

6. CLIENT RIGHTS

Your rights as a client of Sierra County Behavioral Health include the following:

1. The right to be treated with **respect** and with due consideration for your **privacy**.
2. The **right to receive information** on available treatment options and alternatives presented in a manner understandable to you.
3. The right to **participate in decisions** regarding your health care, including the right to refuse treatment.
4. The right to **file a grievance** or appeal a decision without being subject to discrimination or penalty.
5. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
6. The right to request and receive a **copy of your health information**.
7. The right to request that your health record be **amended**.

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7. CAUSE FOR DISCHARGE

- ⇒ If it appears that the services we offer are **not beneficial for you**, a decision could be made to discontinue services.
- ⇒ Failure to treat other clients and staff with **respect** can result in discharge from program services.
- ⇒ **Failure to maintain the confidentiality** of others accessing services can result in discontinuation of services.
- ⇒ Sierra County Behavioral Health reserves the right to discharge clients for reasons not mentioned in this informed consent, should the need arise. Such dismissal from services would not happen without good cause.

8. WEAPONS

Individuals are prohibited from possessing guns, knives (other than kitchen utensils), or other weapons (except for law enforcement officers acting in the line of duty) while at Sierra County Human Services.

9. FOLLOW-UP

Upon discharge from the program, someone from Sierra County Human Services may attempt to contact you to participate in a follow-up client satisfaction survey, with your permission. These surveys assist us with maximizing the effectiveness of our services. If you are willing to participate in a follow-up contact, please initial one of the following:

I am willing to participate in a follow up contact, following discharge from services _____

I am **not** willing to participate in a follow up contact, following discharge of services _____

CLIENT CONSENT TO SERVICES

I have read and understand all conditions set forth in this Informed Consent. I consent to participate in Sierra County Behavioral Health Services.

Client Signature

Date

Witness Signature

Date

Sierra County Behavioral Health Services

GUARDIAN CONSENT FOR MINOR

I have read and agree with the conditions set forth in the Informed Consent. I agree to allow my minor child _____ (name of minor) to participate in Sierra County Behavioral Health Services.

Parent Signature

Date

Minor Signature

Date

Witness Signature

Date