CONSENT FOR MENTAL HEALTH TREATMENT

I, ___________________________________, hereby authorize Behavioral Health and Recovery Services (BHRS) to provide mental health services for me, or _______________, on whose behalf I have the legal authority for consent. I understand that this may include, but is not limited to assessment, testing, diagnostics, mental health treatment, therapy, medication services, and case management/brokerage.

The conditions of treatment and services have been fully explained to my satisfaction and understanding. I am aware that records concerning this treatment will be retained. These records and information will be kept confidential pursuant to California Welfare and Institutions Code section 5328, and all other applicable confidentiality provisions. No information about the treatment provided pursuant to this consent will be released to agencies or persons outside the county mental health system without my consent, except in the case of a medical emergency, for treatment, payment, health care operations, or as otherwise permitted by law.

What is discussed in therapy is confidential unless I consent to its release, or as otherwise authorized or mandated by law. Two such exceptions expressly required by law include those circumstances in which (1) BHRS clinical staff hear or believe that an adult or child is in danger of hurting him/herself or someone else, and (2) there is a reasonable suspicion that a child, dependent adult, or elderly adult has been neglected or abused.

I agree to participate in the completion of assessment forms to ensure quality of care in the delivery of mental health services and other inter-agency outcomes measures.

I understand that an intern or mental health practitioner who is not licensed in the state of California may provide some of the outpatient mental health services. If so, he/she is required by law to receive regular supervision and these responsible licensed clinicians will also have access to the treatment records in order to perform supervision responsibilities. Information disclosed as part of supervised clinical training is protected by the laws of confidentiality and shared only for training purposes that support quality of care.

If I have a problem that I cannot resolve successfully with my clinician and his/her supervisor, I can call the BHRS Complaint/Grievance line at 1-888-818-1115. If I have questions regarding my rights as a BHRS client I can call the Patients' Rights Advocate at (415) 526-7525.

I have read this consent form and I understand its content and agree to its conditions. I understand that I can withdraw consent and terminate from this program and its services at any time by notifying the program providing the services in writing.

Client Name: ____________________________

Client Number: __________________________

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I acknowledge:

1. I have been given a 24/7 phone number in the event of an urgent/emergent need. Crisis Stabilization Unit at (415) 473-6666.

2. I will be asked to participate in developing my treatment plan and goals with my case manager/clinician. I can receive a copy of my Client Plan**.**

3. I have been informed of the availability of Therapeutic Behavioral Service (TBS) and the criteria for receiving these services if **I have a child with Full Scope Medi-Cal.**

4. If my insurance covers mental health treatment, the services provided by an intern or unlicensed mental health practitioner, may not be covered.

5. For any billing questions, I can call the billing department. The billing department number is (415) 473-6816.

6. I have been given the **Grievance Resolution Line #**: **1-888 -818-1115.** I have received a copy of the **Notice of Privacy Practices** [HIPAA Form 01–01], which informs clients how H&HS may use and/or disclose their protected health information

7. If I am a MediCal beneficiary, I have received a **Marin Mental Health Plan Member Handbook** that covers information about Emergency Services, Outpatient Services, Confidentiality, Changing Providers, Patients' Rights Advocate, Grievance Resolution, Advanced Health Care Directive, Fair Hearings and the State Mental Health Ombudsman.

8. I have a right to free interpreter services. I understand that copies of informational materials in alternative formats (e.g. CD, large font, non-English) can be provided by the front desk or your clinician.

9. **If I am 18 years of age or older**, I have been given information re: Advanced Health Care Directives**.** (As required by Code of Federal Regulations 42).

10. I have been offered a copy of the County of Marin, Dept. of Health and Human Services Medi-Cal Provider List.

______________________________________ ______________________

Client/Parent/Legal Guardian/Conservator Signature Date

☐ Client/Parent/Guardian declines to sign but is willing to accept treatment.

______________________________________ ______________________

Clinician/Intern/Case Manager Signature Date

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Printed Licensed Clinical Supervisor's Name and Title (necessary if clinician is an intern)

Client Name: ____________________________

Client Number: __________________________