CONSENT TO RECEIVE TREATMENT AND SUPPORT SERVICES

R12/14/21

I voluntarily consent to behavioral health and/or medical treatment performed by my medical provider and all health care providers of Community Health Alliance and its subsidiaries, Sojourner Recovery Services and Transitional Living which authorizes consent for routine services, diagnostic and laboratory procedures, therapeutic services, medical treatment and other health care services or treatment deemed necessary by the health care providers treating me, which is based upon the professional expertise and judgement of the providers.

I acknowledge by signing this consent that I intend this consent is continuing in nature, even after a specific diagnosis has been made and treatment recommended. I understand that I have the right to consent or to refuse to consent to any proposed diagnostic procedures and/or treatment and to discuss it with my health care provider. I understand that the practice of behavioral health and medicine is not an exact science and that diagnosis or treatment may cause injury or even death and that my health care provider will inform me of the risk and benefits of recommended treatment.

I agree to take an active role in my care and agree to provide accurate information to my health care providers to ensure appropriate care can be provided.

I (we) understand the following rights:

1. Information on the purpose of recommended treatment/services, laboratory and diagnostic procedures, medications and other support provided to me will be explained including my diagnosis (if applicable) and symptoms associated with the diagnosis.
2. The best practice treatment approaches for my diagnosis(es) will be explained to me along with my treatment options including the benefits, limitations and risks associated with treatment and/or services.
3. I will receive information regarding prescribed medications including directions, rationale, common side effects, risks, benefits and treatment alternatives.
4. Information about my service provider's qualifications will be provided.
5. An explanation of potential consequence(s) of refusing or withdrawing consent for treatment or services will be provided.
6. I understand I may refuse treatment or service options provided at any point.
7. I will receive information regarding expectations, rules, rights and grievance procedures. I agree to read this information and seek clarification to ensure full understanding of the expectations of my participation in treatment.

I understand that the information regarding my treatment and/or services is protected by state and federal law, and I acknowledge that I have received a copy of the rules pertaining to confidentiality and these rules have been explained to me.

Follow up Contact:
Do you agree to receive contact after terminating treatment/services? The contact may be by telephone, US mail or email and may occur for up to 24 months after your discharge date.

☐ Yes ☐ No

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable):_____Date: _____

Staff Signature: _____ Date: _____