School-based Behavioral Health - **Informed Consent**

Seeking behavioral health services is an important decision – one that often comes with many questions. This document is intended to inform you of CHC/SEK's policies, state and federal laws, CHC/SEK's responsibilities to you, and your rights as the patient. If you have other questions or concerns, please ask and we will provide you with the information you need.

AVAILABLE SERVICES

CHC/SEK's school-based therapists offer counseling services including individual, family, and group services. CHC/SEK is staffed by skilled and experienced licensed behavioral health professionals ('Care Providers"). Care Providers are not licensed to practice medicine and do not prescribe medications. Certain disorders have medical or biological origins and, in those cases, patients should consult a medical provider.

COUNSELING

CHC/SEK provides various lengths of counseling designed to address varying needs. Your first visit will be an assessment session in which Care Providers and patients assess concerns and develop a plan of care, sometimes called a treatment plan.

If you feel CHC/SEK's Care Provider is not a good fit, please discuss this with your Care Provider to determine if transferring care is right for you. If you and the Care Provider decide that other services are more appropriate, CHC/SEK will assist you in finding a provider to meet your needs.

RISKS AND BENEFITS

Counseling and therapy are beneficial, but as with any treatment, there are inherent risks. During counseling, discussions about personal issues may bring uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem-solving skills. CHC/SEK cannot guarantee these benefits.

CLIENT/THERAPIST RELATIONSHIP

Patients and Care Providers have a professional relationship existing exclusively for treatment. Your Care Provider can best serve your needs by focusing on therapy and avoiding any social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for care.

PATIENT'S RIGHTS

Patients receiving services at CHC/SEK have the following rights (Please refer to CHC/SEK's Patient Rights and Responsibilities document for additional details):

1) To be treated with respect and dignity;
2) To receive quality treatment regardless of race, religion, ethnic origin, national origin, evidence of insurability, sexual orientation, age, disability, medical condition, or ability to pay for services;
3) To be provided confidentiality and protected from any unwarranted disclosure;
4) To be involved in planning treatment;
5) To refuse treatment to the extent permitted by law and to be informed of the possible consequences of your actions; and
6) To expect continuity of care.

PAYMENT/INSURANCE FILING

CHC/SEK provides services regardless of the ability to pay. Students receiving CHC/SEK's school-based services will not be charged a co-pay. If you are using insurance benefits, we will file insurance claims for you and will honor any agreements, restrictions and requirements. A reasonable fee may be charged for copies of any records requested.

EMERGENCIES

You may have situations that require immediate attention. CHC/SEK will attempt to schedule you as soon as possible or to offer other options. If your emergency arises after hours or on a weekend, please call 620-249-5266. If you are experiencing a life-threatening medical emergency, call 911 or have someone take you to the nearest emergency room for help.

CONFIDENTIALITY

Discussions with a Care Provider are confidential. No information will be released without your written consent unless required by law. Possible exceptions include, but are not limited to:

- Abuse, neglect and/or Sexual Exploitation;
- AIDS/HIV Infection and Possible Transmission;
- Criminal Prosecutions;
- Child Custody Cases;
- Suits in which the mental health of a party is at issue;
- A negligence suit brought by the Patient against the Care Provider; or
- The filing of a complaint with the licensing or certifying board.

By signing this Informed Consent, you are giving consent to CHC/SEK and the Care Provider to share information with all entities required by law and also releasing and holding harmless the Care Provider from any departure from Patient's right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT

Under certain circumstances, CHC/SEK Care Providers have a duty to warn/protect the Patient (or minor Patients). CHC/SEK Care Providers rely on education and experience, in addition to state/federal law and regulations when making determinations.

CONSENT TO TREATMENT

As the Patient/Decision-maker of said Patient, I acknowledge reading, understanding, and agreeing to the information in this form. I have had the opportunity to address questions or request clarification for anything that is unclear. I am voluntarily agreeing to receiving treatment for me (or my child), and I understand that I may stop such treatment at any time.

If Patient is consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting Patient's rights to consent to the child's care and treatment, CHC/SEK will not render services to Patient's child until CHC/SEK has received and reviewed the most recent court order.

By signing this Behavioral Health - Informed Consent form, as the Patient or Decision-maker of said Patient, I also am hereby authorizing the release of necessary medical information for insurance reimbursement purposes and authorizing the payment of medical benefits to the provider of services.

_____ _____

Signature of Patient or Decision-maker* Printed Name of Patient or Decision-maker*

*Relationship to Patient: ___Parent ___Legal Guardian

___Durable Power of Attorney ___Other/Relationship:_____

*(*Documentation is required at time of signing Behavioral Health & Addiction Treatment Services - Informed Consent form)*

Date (Month/Day/Year): _____/_____/_____

_____ _____

Signature of Witness Printed Name of Witness

Date (Month/Day/Year): _____/_____/_____