Informed Consent for Services/ Acknowledgement of Privacy Practices Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

I, _____, hereby consent to an evaluation and treatment with Integrated Behavioral Health. This evaluation and treatment may include, but is not limited to individual and family therapy, psychological evaluations, medication management and referral recommendations. This consent will be valid for any Integrated Behavioral Health psychiatrist, nurse practitioner, and/or therapist I see during the course of my treatment to communicate each other in order to make informed decisions concerning my treatment.

I understand that I have the rights as a patient of Integrated Behavioral Health that are as follows:

- Be treated with dignity and respect.
- Choose the services or programs in which you participate based upon information about rules, treatment procedures, costs, risks, rights and responsibilities.
- Ask questions and get answers about services.
- Participate fully in all decisions about treatment or services.
- Request treatment in the least restrictive setting- one that provides the most freedom appropriate to your treatment needs.
- Refuse treatment or service unless ordered by the Court to participate.
- Know the name of the medication you are taking, why you are taking it, and what its possible side effects may be.
- Refuse to take medication, if you choose. (Note: You should not discontinue taking medication suddenly without first discussing the possible dangers with a psychiatrist.)
- Refuse family participation in your treatment, if you choose.
- Not be subjected to verbal, physical, sexual, emotional, or financial abuse; hard or unfair treatment.
- Make complaints, have them heard, get a prompt response, and not receive any threats or mistreatments as a result.
- Review your record, with two exceptions, as limited portions of your records can be withheld from you if your provider(s) feel that seeing specific information would,
    - Be harmful to your treatment, or
    - Reveal the identity or break the trust of someone who has provided information in confidence.
- Not be discriminated against on the basis of race, age, sex, religion, national origin, sexual orientation, disability, or marital status.

I understand that the information about my treatment and communications with my practitioner may not be released without my written authorization. However, these communications or this information may have to be revealed without my permission, as follows:

1. If necessary to protect my safety or the safety of others.
    a) If I am clearly dangerous to myself, my practitioner may take steps to seek involuntary hospitalization and may also contact members of my family or others.
    b) If I threaten to kill or seriously hurt someone and my practitioner believes I may carry out my threat, or if my practitioner believes I will attempt to kill or seriously hurt someone, my practitioner may

- Tell any reasonably identified victim;
- Notify the police; or
- Arrange for me to be hospitalized if necessary for me to be hospitalized for psychiatric care.

2.In court proceedings if a court orders access to my records or subpoenas the provider for testimony, such cases may involve but are not limited to the following: cases involving the care and protection of children or to dispense with the need for parental consent to adoption; in a legal proceeding where I introduce my mental or emotional condition; if a judge thinks the therapist has evidence about my ability to provide care or custody in a child custody or adoption case; if I bring an action against the therapist and disclosure is necessary or relevant to a defense; in a sexual assault or other criminal case.

3. If the therapist believes a child, a disabled person, or an elderly person in my care is suffering abuse or neglect.
4. To provide information regarding my diagnosis, prognosis, and course of treatment or for purposes of utilization review or quality assurance to a third party payer such as my insurance.
5. If necessary to use a collection agency or other process to collect amounts I owe for services.

If any disclosures are made without my permission for the reasons listed above, only the minimal amount of information required for the specific purpose requested will be released.

I have been offered a copy of my Notice of Privacy Policy and have:

____ declined a copy but am familiar with my rights; also understand they may ask for a copy at any time during my treatment.
____ received a copy of the policy and am aware of my rights.
____ received and reviewed a copy of the policy with the counselor.

I, or my authorized representative herby give consent to Integrated Behavioral Health to take my photograph. I understand this photograph will be stored in the EMR system for identification purposes.

I have the opportunity to discuss this informed consent statement with my provider and/or office staff. I understand its meaning and consent to receiving services based on this understanding.

_____ Date: _____
Signature of Patient or Person granting Authorization on behalf of patient

_____
Printed Name of Person Signing (if not the patient) Relationship to Patient

_____ Date: _____
Witness Signature: