

COUNTY OF SISKIYOU BEHAVIORAL HEALTH SERVICES

# Consent to Treat

## **Purpose**

I would like services for myself or my child from County of Siskiyou Health and Human Services Agency and/or its contracted providers. I understand this document contains information about services that may be provided to me or my child. I understand that I have the right to speak with a provider about the information in this document and ask questions in order to understand this information.

## **My Right**

I acknowledge I was informed of my/my child's rights as a client and that I was offered the consumer rights document, which contains my/my child's rights as a client.

## **Private Practices**

I acknowledge I have been offered a copy of County of Siskiyou Health and Human Services Agency's Notice of Privacy Practices, which has information about how my/my child's private health information may be used and disclosed under the law. I understand that in certain circumstances information I share must be disclosed. For example, behavioral health providers are mandated to report if there is a reasonable suspicion of child, elder, or dependent-adult abuse or neglect; if there is a threat to my/my child's physical safety; or if there is a threat to the safety of others.

I understand that if my child is receiving services, in certain cases the provider of those services may not be able to share information with me about those services unless my child permits them to do so.

## **Services**

I understand that the services that may be provided focus on mental health and substance use issues. I am aware my/my child's information and records may be shared between mental health and substance use programs and providers for the purpose of providing treatment, to the extent permitted by law.

## **Risk and Benefits of Services**

I understand behavioral health services may have risks and benefits. I am aware that behavioral health services may involve discussing difficult aspects of my or my child's life and making changes to psychiatric medication I or my child may take and/or substance use treatment. I or my child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. I or my child may also experience an increase in the symptoms as I or my child work through issues or as my or my child's medications are being changed and/or added to in the course of treatment.

I am also aware behavioral health services have been shown to have benefits. For example, psychotherapy and/or substance use treatment may lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Psychiatric medication may alleviate symptoms of mental health issues.

I understand there are no certainties about what I or my child will experience as I or my child receive services and how successful services will be. I understand behavioral health services require an investment of time and effort from all involved and openness to what change and success may look like.

## **Services are Voluntary**

I understand participation in behavioral health services is voluntary, except for certain situations where County of Siskiyou Health and Human Services Agency is legally required to provide services even if it is involuntary, such as 5150 psychiatric holds or conservatorships.

I understand that even if a court orders me to participate in behavioral health services, I can still choose not to participate in services. I am aware that consequences that may arise due to my decision not to participate in court-ordered services are my responsibility. I understand that I may speak with an attorney, probation officer, and/or Child Welfare Services worker to make the best possible decision regarding participating in court-ordered services.

**Eligibility for Services**

Eligibility for behavioral health services is determined by a combination of laws, regulations, and local policies. I understand that if an assessment determines that I/my child is no longer eligible for behavioral health services, the reasons will be discussed with me and I will also be provided with a notice of adverse benefit determination (NOABD) that explains these reasons and information on the appeals process. I will then be given referrals to other service providers, as appropriate, that may meet my or my child's needs.

**Service Providers**

I understand that providers come from different educational and professional backgrounds and have a variety of experience levels and licensure and that providers only provide services that are allowed by law for their specific education, experience, profession, and licensure.

I understand that County of Siskiyou Health and Human Services Agency may utilize some unlicensed professionals that are in the process of completing their requirements for clinical licensure but who are authorized by law to provide mental health services under the supervision of a licensed mental health professional. I understand I or my child may receive services from some of these individuals, who will clearly identify themselves, as well as their supervising provider/clinician. I understand I may call the supervising licensed clinician if I have any questions about this arrangement

**Availability of Providers and Crises/Emergencies**

I understand providers are generally available during regular county business hours, which are Monday thru Friday 8am to 5pm, except during county holidays. I understand that some programs have different hours of availability. For non-urgent matters after-hours, I understand I or my child can leave messages in the provider's confidential voicemail (if they have one available) or with County of Siskiyou Health and Human Services Agency's after-hours telephone service. For urgent or crisis situations, I or my child can contact: 24-Hour Toll-Free-Telephone Line at: 800-842-8979.

For emergencies, I understand my family or I should call 911.

**Change of Clinician/ Provider**

I understand I can request a change of mental health provider at any time by completing a Change of Provider form, which is available at all clinics. I understand requesting a change of provider does not guarantee a change, and there may be significant administrative or treatment issues that may not make the change possible. I understand a supervisor or manager will provide me the reason(s) the change is not possible.

**Fees and Billing Medi-Cal, Medicare, and/or Insurance**

I understand County of Siskiyou Health and Human Services Agency will ask me to provide my financial information on an annual basis and this information will be used to calculate service fees that I may be responsible for paying. For substance use treatment services for Drug Medi-Cal Beneficiaries, Drug Medi-Cal funding shall be accepted as payment in full.

I understand any private insurance will be billed by County of Siskiyou Health and Human Services Agency before billing Medicare and/or Medi-Cal. I understand I may consult with my private insurance, Medicare social worker, and/or Medi-Cal eligibility worker if I have any questions about my or my child's coverage, deductibles, and co-pays.

**Additional Documents for Medi-Cal Clients**

I understand the Guide to Medi-Cal Mental Health Services handbook and/or the County Beneficiary Handbook for Substance Use Disorder Services contains details about behavioral health benefits for Medi-Cal beneficiaries. I have been offered a copy of all relevant handbooks and understand that they're available in all clinics.

**Complaints and Grievances**

I understand I may file a complaint or grievance if I am dissatisfied with the services I or my child receives from County of Siskiyou Health and Human Services Agency and its contracted providers. I understand I or my child will

not be subjected to any penalty for filing a complaint, grievance, or an appeal. I was offered a copy of the Problem Resolution document, which explains how I can file a complaint, grievance, or appeal.

**Complaints to the Licensure Board**

I understand that the California Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of professional clinical counselors, marriage and family therapists, licensed educational psychologists, and clinical social workers. I understand that I may contact the board online at [www.bbs.ca.gov](http://www.bbs.ca.gov), or by calling (916) 574-7830.

**Informed Consent**

By signing, I acknowledge that I understand the information contained in this document and I agree to my receipt, or my child's receipt, of behavioral health services in accordance with the terms described above.