Aurora Family Service®

CONSENT FOR OUTPATIENT BEHAVIORAL HEALTH SERVICES

Consent for Treatment (Please read and sign below)

The staff of the Aurora Family Service want you to be aware of your rights as a consumer of the outpatient mental health services provided in our clinics and requests your informed consent to treatment. Your signature below indicates that you have received, reviewed and are in agreement with the following:

A. You will be informed of the results of the initial assessment.

B. You will be informed both orally and in writing regarding all of the following:

1. Treatment alternatives, such as: higher levels of care, community support groups, group psychotherapy, etc.
2. The outpatient behavioral health services that will be offered and the possible outcomes and side effects of treatment that is recommended including the possibility of:
   - Upsetting insights
   - Discouragement if progress is not as quick or as substantial as anticipated
   - Feelings of stress
   - Change in relationships
   - Medication sides effects if medications are prescribed (These will be discussed with your prescribing provider)
   - Other (please specify) _____
3. Treatment recommendations and the benefits of these recommendations. Potential benefits include but are not limited to:
   - Decrease and/or discontinuation of symptoms
   - Improved understanding of self and others
   - Progress towards goals and objectives
   - Increase in sense of self-worth
   - Increase in assertive behavior
   - Improved relationships with others
   - Increased capacity for independent behavior
   - Increased use of healthy coping strategies for distress
   - Increased confidence in the ability to manage control over thoughts, feelings, and behaviors
   - Other (please specify) _____
4. The approximate duration and desired outcome of the treatment recommended as documented in your Service Plan(s).
5. Received a copy of Aurora Health Care's Notice of Privacy Practices outlining **conditions for disclosing protected health information** in addition to **limits of confidentiality**. ☐ **Received** ☐ **Declined**
6. Received a copy of the Missed Appointment and Late Cancellation Policy including circumstances under which a client may be discharged for administrative reasons. ☐ **Received** ☐ **Declined**
7. Received a copy of the Aurora Family Counseling Clinic brochure and have been informed of the following information:
   - Fees for service
   - Safety and confidentiality
   - How to obtain emergency behavioral health services during periods outside normal operating hours of the clinic
   - Client Rights and Grievance Procedure ☐ **Received** ☐ **Declined**
8. I understand my applicable treatment fees and my responsibility in payment and that if I am unable to make payments according to the agreed upon payment plan that I may make a formal request for a new payment plan, in writing, to the Manager of Clinical Services. I understand that the following sliding fee scale payments or insurance co-payments are my responsibility and due at the time of service:
   ☐ **Client Self Pay Amount: $_____** ***or*** ☐ **Co-Pay Amount: $_____**
9. I have been offered a copy of this signed Informed Consent for Treatment. ☐ **Received** ☐ **Declined**

Duration

This consent for treatment will remain in effect until treatment is terminated but not longer than 15 months. You have the right to withdraw your consent for treatment at any time in writing. Please feel free to speak with your provider about any questions or concerns you have. We look forward to working with you.

Signature of Patient of Record (Minors ≥age 14 included) Date/Time

Signature of Parent/Guardian (for minors) or Co-patient(s) Relationship to Patient of Record Date/Time

Provider Signature Date/Time

revised 12/2016