**Informed Consent for Mental Health Services**

**Informed Consent Prior to the Initiation of Mental Health Services:** In effort to provide the most effective treatment possible, the staff of RISE Behavioral Health and Wellness believes it is important for potential clients to understand the client or guardian knows all of the risks and costs involved in the treatment, including the nature of treatment, possible alternative treatments, and potential risks and benefits of the treatment.

Consent must be given by the parent or guardian for a child under 12 years of age. A child 12 through 17 years of age can consent to treatment for 5 outpatient sessions no more than 45 minutes in duration.

If the client is determined to be in need of crisis services or if the assessment is court ordered for the client, consent is not required.

Legally competent adults who participate in treatment services are deemed to have consented.

Oral consent shall also be documented in the record.

**Therapy and Counseling:** The therapeutic interventions implemented by the individual’s assigned counselor is based on the results of the initial and ongoing assessment of the individual’s specific needs that considers diagnosis, severity, and symptomatology, as well as the input of the individual’s preferences. Treatment interventions frequently used, but are not limited to, the following: cognitive behavioral, person centered, interpersonal, solution based brief therapy, play therapy, decision making, motivational interviewing, family counseling, narrative therapy (transactional analysis). Therapy services may be provided in individual, group, or family sessions.

**Length of Services:** The length of therapy and/or the overall mental health treatment is based on individual needs and preferences. An approximate range of treatment duration may consist of initial assessment only or up to six months for moderate severity and one to two years for more chronic, severe conditions. For individuals receiving longer term treatment, a review of progress is completed at least every six months in order to determine additional and/or effective treatment recommendations for assisting the person in successfully transitioning to natural supports.

**Alternative Treatment:** Alternatives to outpatient mental health services may involve participation in self-help groups, faith based services, healthcare clients, and/or community agencies that could provide assistance to the individual.

**Risks and Benefits of Treatment:** All formal treatments and alternative treatments can pose certain risks. These risks can include, but are not limited to, emotional discomfort, recollection of painful memories, and possible disruption within the family system. In cases in which an individual is seeing the agency psychiatrist, the risks and benefits are discussed in depth with the agency psychiatrist. The benefits of treatment include, but are not limited to, an improved sense of emotional well-being, ability to independently manage mental health symptoms, improved family relations, return to employment, improvement of academic performance, less hospitalizations, and attainment of natural supports within the community.

**Cost of Treatment:** Client’s financial responsibility is determined by the co-pay assigned by the individual’s insurance carrier, Fee for Service funding, or private payment, which is based on our sliding fee scale and can range from $25 to $100 per hour. All fees may be adjusted or established based on the individual need of the person served and with the approval of the Executive Director or an assigned agent. In a situation where an individual is assessed at high risk for crisis or imminent hospitalization without specific mental health interventions, the priority will be to offer services to stabilize the individual, regardless of their ability to pay. Cost for services is based on an individual need and may range from $0 to $100. Payment is appreciated at the time of service. **Inability to pay for services should not serve as a reason to cancel or reschedule appointments.**

My fee for services will be as follows:

* **Fee for Service**
	+ Counseling Fee: $\_\_\_\_\_\_\_\_\_\_
	+ Psychiatric Appointments: $\_\_\_\_\_\_\_\_\_\_
		- Monthly Household Income: $\_\_\_\_\_\_\_\_\_\_
		- Monthly Client Income: $\_\_\_\_\_\_\_\_\_\_
* **State Insurance**
* Medicaid
* Managed Care
	+ Molina
	+ Meridian
	+ Blue Cross Blue Shield
	+ IlliniCare
* **Private Insurance**

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co Pay: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coinsurance: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deductible:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Met Deductible:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Amount owed at time of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Additional Services** **Provided** *(may not be covered by insurance)*
	+ Mental Health and Psychiatric Evaluations (approximately two hours): $175
	+ Domestic Violence/Anger Management Intake (approximately two hours) $160
	+ Mediation $80/hour

***We will need for you to sign a Release of Information to your insurance company so that we may bill for services rendered.***

I understand that the above amount is due for services rendered and is due at the time of service, including insurance co-payments, unless other arrangements have been made. I also understand that failure to pay for these services may result in legal action against me, and court proceedings in Douglas County are printed in the local newspapers.

By my signature on this form, I acknowledge that I understand the nature of treatment services, the cost of treatment, and I give my consent to receive services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

Oral consent given by client/parent/guardian? \_\_\_\_\_\_ Yes Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I believe the client and/or parent/guardian understood the elements of informed consent for treatment.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature Date