

## CONSENT TO TREATMENT

I voluntarily consent to receive drug, alcohol, and/or mental health treatment services from the Summit County Combined General Health District ("SCCGHD").

I understand that services may be provided by independently licensed counselors, social workers, chemical dependency counselors, prevention professionals, and/or trainees, or other SCCGHD staff working within the scope of their credentials, training, and supervision, as permitted by law and the SCCGHD agency policy.

The nature, purpose, risks, and benefits of recommended treatment services have been explained to me. I have had the opportunity to ask questions about the services recommended to me and have received answers I understand. I may participate in treatment planning and may refuse recommended services, except when required by law or court order. Refusing services or failing to participate in treatment may affect my treatment progress and may have consequences if I was referred by a court or other agency.

SCCGHD does not guarantee any particular outcome or result from treatment.

I have been informed of the risks and benefits of participating in each proposed treatment or alternative treatment and/or no treatment. I have used the information provided to me to voluntarily decide whether I will participate in or refuse recommended services.

I agree to cooperate with treatment, keep scheduled appointments, and follow program expectations. SCCGHD may determine that services are no longer appropriate, available, or effective for me, consistent with applicable law, clinical judgment, and agency policy, and I may be referred to another provider or level of care when appropriate.

SCCGHD may bill me and/or my insurance, if applicable, for covered services provided to me, and I may ask questions about fees, billing, and payment responsibility.

I have received or been offered the following, as applicable:

- Notice of Privacy Practices
- Client Rights Policy
- Client Grievance Procedure

My treatment records are confidential and protected by state and federal law, including HIPAA and, when applicable, 42 CFR Part 2. SCCGHD generally cannot disclose protected information about me without my written permission unless disclosure is permitted or required by law, including in situations involving a serious and imminent threat to health or safety. A separate written authorization/release of information is required for most disclosures to courts, probation,

parole, Children Services, family members, employers, schools, or other outside persons or agencies, unless otherwise permitted by law.

No person shall be excluded from participation in SCCGHD services or otherwise be subjected to discrimination in violation of applicable federal or state law.

I have the right to voice concerns, complaints, or grievances regarding my care, and that I may do so without fear of retaliation. I understand that I may file a grievance according to SCCGHD policy and procedure.

**Appointment Reminder Permission**

Please check one:

Yes, I give SCCGHD permission to leave appointment reminder messages at the following phone number(s):

No, I do not give SCCGHD permission to leave appointment reminder messages.

I acknowledge that I have read (or had read to me), understand, and agree to this Consent to Treatment. By signing below, I consent to treatment and agree to the terms described in this form.

Client name (print): \_\_\_\_\_

Client date of birth: \_\_\_\_\_

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or legal guardian name (if applicable): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SCCGHD staff name (print): \_\_\_\_\_

Staff signature: \_\_\_\_\_ Date: \_\_\_\_\_