BEHAVIORAL HEALTH SERVICES

TREATMENT CONSENT FORM

This document contains important information about the professional behavioral health services and business policies of Wahiawā Center for Community Health (Wahiawā Health). In order to help you decide whether to begin services with the Behavioral Health providers at Wahiawā Health, it is important that you consider all of the information described in this consent form. These services are elective – you are not required to participate and your access to other services within our community health center is not contingent upon your decision to receive behavioral health services.

Behavioral health services promote well-being by preventing or intervening in mental illness such as depression or anxiety. Services also aim to prevent or intervene in substance use disorders or other addictions. Services with your provider begin with a period of diagnostic evaluation involving a clinical interview, and you may also be asked to complete personal history and symptomatic questionnaires and standardized psychological assessment measures. Subsequently, you and your provider will collaborate on the development of a treatment plan typically involving a combination of cognitive-behavioral, insight-oriented, motivational, medication, and supportive therapies that are provided in individual and group formats. Behavioral Health services are the most successful when you work on things both in sessions and at home.

Behavioral Health services can have risks and benefits. There are no guarantees regarding what your personal experience will be. You might discuss unpleasant aspects of your life and experience uncomfortable feelings during sessions. On the other hand, behavioral health services have been shown to have benefits such as improved relationships, increased adaptive coping strategies, and reduced feelings of distress, to name a few.

ACKNOWLEDGEMENT:

- I am aware that the practice of behavioral health is not an exact science. I acknowledge that Wahiawā Health has not made any guarantees to me as to the result of treatment or examination. I am also aware that I should ask my provider(s) any questions that I may have about my diagnosis, treatment, and/or anticipated results of treatment.
- For patients receiving psychological evaluation: I understand that the testing process involves personal interviews and the completion of a variety of psychological assessment instruments. The total time of the evaluation may vary. I understand that I might experience emotional distress because of the personal nature of some of the information solicited by the testing process. I know that my provider may interrupt or discontinue this testing process at any time.
- I am aware that I may stop my treatment with Behavioral Health Services at any time. The only thing I will still be responsible for is payment for services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court system.)
- I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any behavioral health services or treatments I receive for billing purposes. If I choose to pay for all charges myself, I will notify the Behavioral Health staff prior to receiving services.

- I agree to maintain my personal safety during my work with Behavioral Health Services, which includes not bringing weapons to any sessions.
- I fully understand the limits to confidentiality and I understand that there may be circumstances in which the law requires our providers to disclose confidential information, such as if I present an imminent danger to self or others, I authorize a release of information with my written consent, child or elder abuse is suspected, or there is a valid court order in legal cases.
- I understand that all medications are prescribed by licensed psychiatrists or nurse practitioners, and I understand that I may be required to complete laboratory testing or urine drug screening prior to treatment.
- If a refill on medication is needed, I agree that this request should be made **at least seven (7) days in advance** to allow adequate time to process my request. I understand that it is my responsibility to call the clinic directly at (808) 622-1618, extension 406 to request any refills. I understand that notification reminders and requests from a pharmacy will not automatically generate a refill. This is for my benefit, as psychotropic medication are adjusted on a consistent basis based on current symptoms. If I am experiencing any negative side effects, I agree to contact the office for a sooner appointment, if deemed appropriate by my provider. For serious negative side effects, I will go to the nearest emergency room.
- I understand that if I am receiving medications from the Behavioral Health department, I will also need to maintain my regular follow-up appointments with my established mental health therapist, which will be verified on an ongoing basis by my medication prescriber.

Please understand that the Behavioral Health Services at Wahiawā Health are not designed to manage urgent or emergency behavioral health concerns. In the event that you require immediate assistance for these concerns, you should present to the nearest emergency department, call 911 for emergency services, or call the Hawai‘i C.A.R.E.S. Crisis Line at (808) 832-3100 (neighbor islands call toll-free at 1 (808) 753-6879).

This form documents your consent for behavioral health services with the providers at Wahiawā Health. This form supplements notices pertaining to our organization's terms and conditions of service, privacy practices, confidentiality of healthcare records, and your patient rights and responsibilities. As one of our valued patients, we encourage you to ask us to clarify any information pertaining to information in this form or your participation in our programs.

Patient Statement of Understanding and Informed Consent for Treatment

I acknowledge that I have read or have had read to me the information outlined in this form and consent to assessment, evaluation, and treatment at Wahiawā Health's Behavioral Health Services department. By signing this form, I hereby consent to treatment with the Behavioral Health providers at Wahiawā Health and agree to the guidelines discussed above.

Patient Name	Patient/Legal Guardian Signature	Date

Witness

I have explained the nature, anticipated benefits, and potential risks of the proposed Behavioral Health Services.

Witness Name (print)	Witness Signature	Date