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.
- 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 three (3) 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 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, and will be scheduled if deemed appropriate by my provider. For serious negative side effects, I agree to go to the nearest emergency room.
- For patients receiving psychological evaluation services:
    - **Purpose & Scope of Evaluation:**
      I understand that the purpose of this psychological evaluation is to assess my cognitive, emotional, personality, or behavioral functioning as requested by myself, my healthcare provider, or a third-party referral source (e.g., school, employer, court, or other agency). The results will be used to inform diagnosis, treatment planning, or other necessary interventions.
    - **Confidentiality & Limits of Privacy:**
      I understand that the information obtained during my psychological evaluation will remain confidential except in cases where disclosure is required by law, including but not limited to suspected child abuse, elder abuse, imminent risk of harm to myself or others, or if ordered by a court of law.
    - **Use & Release of Evaluation Results:**
      I acknowledge that the results of this evaluation may be shared with my referring provider or other authorized parties upon my written consent. However, if this evaluation is being conducted at the request of a third party (e.g., court-ordered, school, or employer-related evaluation), I understand that the results may be shared with that entity as permitted by law.
    - **Fees & Insurance Coverage:**
      I understand that psychological evaluations may not be fully covered by insurance and that I am responsible for any uncovered costs. If an evaluation is discontinued by my provider or if I choose not to complete the process, I may still be responsible for fees associated with services already rendered.

- **Testing Conditions & Expectations:**
  I understand that I must fully participate in the evaluation process, which may include multiple sessions, interviews, questionnaires, and computerized or written assessments. Any attempt to falsify responses, withhold information, or distort results may affect the validity of the assessment.
- **Access to Results & Interpretation:**
  I understand that I have the right to review the findings of my psychological evaluation with my provider. My provider will explain the results in a way that is clear and useful for my treatment planning or other relevant purposes.
- **School-Based Psychological Evaluations & Legal Limitations:**
  If psychological testing is conducted in the school-based health clinic, I acknowledge that the assessment is being completed in collaboration with the Hawai‘i Department of Education (DOE) and is intended solely for educational and clinical purposes—not for litigation or legal proceedings. I understand and agree that neither I nor my child (if applicable) will subpoena Wahiawā Health or its providers to testify or provide records in any legal case against the DOE.
- **Right to Decline or Withdraw:**
  I acknowledge that I have the right to decline participation in a psychological evaluation or withdraw my consent at any time. However, I understand that refusal to participate may impact the ability to make informed clinical, legal, academic, or occupational recommendations.

RESPECTFUL CONDUCT

- It is expected that patients behave respectfully towards Wahiawā Center for Community Health (Wahiawā Health) personnel for the duration of their treatment. Any abusive or disrespectful behavior could result in dismissal from Wahiawā Health’s care. Inappropriate behavior includes but is not limited to, offensive remarks (e.g., excessive profanity, racial remarks, sexual slurs), harassment, stalking, acts of aggression (e.g., threat of, or actual acts of violence, willful property damage), or possession of a weapon, alcohol, or illegal drugs on premises.

CONFIDENTIALITY

- Federal and state law protects the privacy of all communications between a patient and provider. In most situations, your Protected Health Information (PHI) can only be released to others if you sign a written authorization form that meets certain legal requirements imposed by the Health Insurance Portability and Accountability Act (HIPAA). Please inform your provider if you have any questions or concerns regarding confidentiality. Below is a description of some of the exceptions in which Wahiawā Health is permitted or required to disclose information without your

consent or authorization.

Suspected Abuse or Neglect

- There are some situations in which we are legally obligated to take action to protect others from harm, even if there is a need to reveal some information about a patient's treatment. Hawai'i has mandated reporting laws that require healthcare professionals to report any suspected or confirmed child, elderly, or disabled person abuse or neglect to the appropriate state agency.

Harm to Self or Others

- In the rare event that this type of situation occurs, your provider will make every attempt to fully discuss this with you before taking any action. If you present a clear and imminent risk to harm yourself or others, we are required to take protective actions which may include but is not limited to, seeking hospitalization, contacting law enforcement, and/or contacting family members or others who can provide protection.

Legal Proceedings

- In most legal proceedings, you have the right to prevent your provider from disclosing any information about your treatment. However, a court may order providers to release information, records, and/or testimony in some legal proceedings, and your provider may need to comply with the valid court order.

Professional Consultation

- It may be helpful to consult other professionals about your care at times. During a consultation, every effort will be taken to avoid revealing information that could personally identify you as the patient. The consultant is also legally bound to keep the information confidential. You may not be informed about these consultations, unless it is essential for your treatment process.

Business Associates

- The law requires Wahiawa Health to have formal business associate agreements with certain companies who may come into contact with patient information, such as companies who provide billing and claims processing, practice management software, legal consultation, IT support, and encrypted e-mail. Upon your request, you can receive the names of these businesses. The business associate agreements with these companies indicate their agreement to maintain the confidentiality of your information as required by law or as allowed in the contract.

PROFESSIONAL RECORDS

The law and standards of the Behavioral Health professions require that we maintain treatment records of the services you receive. You are entitled to receive a copy of your records if necessary, unless seeing the records would be emotionally damaging; if this is the case, another Behavioral Health professional can review them with you to help you determine the need for access to your records. Your treatment record contains professional notes and can be misinterpreted and/or upsetting to untrained readers. It is highly

recommended that if you need your treatment records, you request a summary as an alternative. You may be charged a fee for preparing copies of records or any professional time spent in responding to information requests.

CONTACT OUTSIDE OF SESSIONS

Policies regarding contact outside of Behavioral Health appointments assure the security and confidentiality of your information and are consistent with professional ethics and the law.

Phone Communications

- Behavioral Health providers are often not immediately available by telephone. When unavailable during normal clinic hours, you can leave a message with the front desk staff or confidential voicemail. Every effort will be made to return your call within 48 hours. If you are experiencing a crisis, please do not leave a message. Instead, go to the nearest emergency room, dial 911, or call the crisis line at (808) 832-3100. Behavioral health providers do not accept e-mails or text messages regarding clinical matters.

Social Media

- The Behavioral Health providers at Wahiawā Health do not connect with any patients through any social media platforms. These types of social contacts can create significant security risks for you and can affect your treatment.

Web Searches

- Wahiawā Health will not use web searches to gather information about you without your permission, as this violates your privacy rights. During this time of advanced technology, there are vast amounts of information available about individuals on the internet. We ask that you respect the privacy of our Behavioral Health team by not accessing information online about any staff members, as the information may be inaccurate and can impact your professional relationship with your providers.

VALUABLES

As a patient, I am encouraged to leave personal items at home or give to a family member for safekeeping during appointments. Wahiawā Health is not liable for the loss or damage to any money, jewelry, documents, eyeglasses, dentures, hearing aids, cell phones, laptops, other personal electronic devices, or any other personal property.

CONSENT TO MEDICAL PROCEDURES

I consent to the customary procedures and therapies that may be performed while I am receiving outpatient services. These may include, but are not limited to, medication administration, laboratory procedures, telehealth services, or transfer to hospital services under the general and special instructions of my provider. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment in this health center.

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 988 or (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. My signature indicates that I understand that my consent is completely voluntary, and I can withdraw my consent at any time.

Patient Name (print)	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