

INTERCOMMUNITY ACTION, INC.
INFORMED CONSENT FOR BEHAVIORAL HEALTH PROGRAMS

Participant Name: _____ BSU#: _____

I, _____ hereby consent and authorize Intercommunity Action (Interact) to provide services to myself/my child in accordance with reasonable treatment standards, practices and procedures under the following level(s) of care:

- MH Outpatient/Psychiatric D&A Outpatient D&A IOP BHRS (wraparound) Crisis
- Blended Case Management STS Other: _____

_____ I understand that treatment/service at Interact is a collaborative process and does not guarantee a cure for any participant consenting to treatment.

_____ I understand that Interact may recommend to end treatment if and when the treatment team in collaboration with myself determines that I/my child have/has not participated in the treatment plan or process. I understand that I have the right to refuse any treatment that I think is inappropriate or not in my/my child’s best interest. I understand that I have the right to withdraw from treatment at any time.

_____ I understand that if I am enrolled in more than one program in Interact’s Behavioral Health Division, it may become necessary for staff in those programs to communicate with each other. While written authorization will not be requested, I understand that staff will discuss these communications with me and I consent and/or authorize this communication to take place.

_____ I understand that I have the right to confidentiality of my/my child’s record. I understand that information regarding my treatment can be released with my consent for the purpose of obtaining third party reimbursement for my/my child’s mental health treatment and to medical personnel for diagnostic and treatment purposes. I understand that information I disclose during the course of my treatment is confidential and may not be released without my consent, except in limited situations, including but not limited to potential harm to self or others (court order required for D&A participants), medical emergency, specific court orders, if I commit a crime on Interact premises, for reporting child abuse/neglect and overriding statutory or regulatory rules and requirements. All Federal and State regulations for D&A participants will be followed.

_____ I have reviewed and been offered a copy of Interact’s Notice of Privacy Practice.

_____ I give express permission to be contacted (circle each) by telephone, by text message, by email or in writing in the event that I need to be reached by Interact. This includes permission to leave appointment confirmation messages.

_____ I have been informed of the program’s criteria for admission, treatment, completion and discharge.

_____ Policies around hours of operation, attendance, fees and services have been explained fully.

_____ I have been given a copy of Interact’s Participant’s Rights and Grievance Notice. It was reviewed with me and I understand it.

_____ I have been asked if I have a Mental Health Advanced Directive.

_____ I affirm that there is no legal contract (eg: custody agreement) that precludes me from giving sole consent for my child’s mental health treatment. If legal contract exists, Interact requires consent from both parents.

_____ I understand that this consent will be in effect for the entirety of my involvement with Interact.

_____ I understand that I may change my mind regarding this consent at any time however actions that have already taken place regarding this consent may not be changed.

_____ A copy of this consent and the above information has been offered to me.

Participant (Parent if under 14 for MH Only)
(signature)

Participant age 14-18 informed of
of rights – MH Only (signature)

Witness (staff signature)

Date: _____

Date: _____

Date: _____