Rights and Responsibilities/Consent for Behavioral Health Treatment

This notice discusses your rights and responsibilities as a behavioral health client and serves as informed consent for treatment. Your signature indicates that you agree to follow the guidelines outlined here, that of your provider commits him/her to do the same. Your rights as a client are established by Section 17-205a-206k, Connecticut General Statutes, CT licensing regulations for Licensed Psychiatric Outpatient Clinics for Adults and Norwalk Community Health Center policies. Client information may also be protected by Federal confidentiality regulations (42CFR, Part 2). HIPPA policies have been provided at the time of registration as a client.

Behavioral Health Services

Behavioral health treatment is not easily described in general statements. It varies depending on the personalities of the provider and patient, and the particular problems you bring forward. There are many different methods used to deal with the problems that you hope to address. Behavioral Health treatment calls for a very active effort on your part. In order for the treatment to be most successful, you will have to work on things we talk about both during our sessions and at home.

Behavioral health treatment can have benefits and risks. Since treatment often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, behavioral health treatment has also been shown to have benefits for people who go through it and often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Behavioral Health Records

The laws and standards for behavioral health treatment require your provider to keep treatment records. You are entitled to receive a copy of the records unless your provider believes that seeing them would cause you or someone else harm, in which case we will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or be upsetting to untrained readers. It is therefore recommended that you review them in the presence of your behavioral health provider so that you can discuss the contents.

My rights as a client of NCHC Behavioral Health include:

1. To be treated without regard to race, creed, religion, sexual orientation, gender identity and/or gender expression, or mental or physical handicap.
2. To be treated safely, fairly, and with respect for personal dignity and privacy in the least restrictive environment.
3. To be treated in accordance with an individualized care plan. I will be involved in the development of this plan and participate in regular reviews of the successes and challenges of meeting treatment goals. These goals will be updated as needed.
4. To have everything I do and say, and have my case record, kept confidential except as required by state and federal laws. As mandated, staff will report suspicion of child abuse to the CT Department of Children and Families and suspicion of elder abuse to the CT Department of Social Services. We

will protect client records to the full extent of the law, should they be subpoenaed for court, and will release them without client/guardian permission only in the case of a court order to do so.

5. To give my written permission for any video or audiotaping of myself and/or my child and before inclusion in any research project. I understand that I am under no obligation to participate in any of these activities or projects.
6. If I am under 18 year of age I may seek drug or alcohol counseling without my parent's consent. If there is reason to believe that notifying my parent's about my seeking treatment would cause me harm or cause me not to seek treatment I may be seen up to 5 times without my parent's consent upon the approval of my therapist and the Director of Behavioral Health or designee in accordance with CT General Statutes Sec 19a-14c. All other treatment of minors requires parental consent.
7. Upon request, I will be provided with the educational or professional background of all of my treatment providers.
8. All clients seen in more than one treatment program receive integrated care through a shared electronic health record.
9. Our offices are open Monday –Thursday 8:00am- 8:00pm, Friday 8am-5pm and Saturday 8:00am-12pm. Ask your therapist or other staff for up to date information about the department which you are being seen. Call the main number for after hour coverage.
10. If I am not happy with any aspect of the care I receive, I may notify my therapist or any other staff member who will be able to help me complete a feedback form for review by administrative staff. I may notify the Director of Behavioral Health of any concerns or contact the Chief Medical Officer.

My responsibilities as a client of NCHC Behavioral Health include:

1. To participate in treatment planning and to follow the agreed upon care plan.
2. To comply with the rules of the program to which I am assigned, as applicable. These include following the rules that all sites are tobacco free and weapon free, and refraining from threatening or violent behavior while on site. If impaired and deemed to be unsafe, "911" will be contacted.
3. To give at least 24 hour notice of any cancellation of a scheduled appointment. If two or more consecutive appointments are missed without giving 24 hours' notice, or 3 appointments within 3 months are missed I will be discharged from treatment. If I decide that I want to resume treatment a new intake will need to be scheduled and kept.
4. To come to all sessions alcohol and drug free.
5. To pay the fees that I have agreed to pay. Co-pays are due at the time of the session.
6. To respect the privacy of other clients seen at the clinic.
7. To arrange for the administration of medications. The behavioral health department provides medication assessment, prescription(s) for medication as needed, and medication management but does not dispense or administer medication. If I, or my child, are prescribed a medication I will make an appointment in advance of my medication running out. In cases where I am unable to do so I understand that I should contact my pharmacy to ensure there are no refills available for my medications prior to requesting a refill. I understand that I must request all refills at least 7 days in advance of the day that they are needed in order to ensure that my refill are processed in a timely manner. Refills should first be requested through the pharmacy.

8. To have an adult accompany all minor children to treatment in all Behavioral Health clinical settings. This adult must be available during the treatment to be available in case of emergencies. The therapist and parent/guardian may make other written agreements for drop off and pick up for child clients.
9. All clients who receive services in a program partially or fully funded by the State of Connecticut agree to have demographic information send to the pertinent state agency.
10. Any client with an advance directive (ex: Healthcare Proxy, Living Will, Power of Attorney, Conservatorship) should notify staff of this fact so that it may be recorded in our records.

Consent for Treatment ***I give consent to receive behavioral health services for myself (or give permission for my minor child ____) to receive behavioral health services to be given by staff of the Norwalk Community Health Center I have been informed about the services offered, have had an opportunity to ask questions, and an in agreement with them. I understand that I may revoke my consent at any time by giving written notice to the Norwalk Community Health Center***

_______________________________	__________________________________	__________
Printed name of client/guardian	Signed name of client/guardian	Date

My signature indicates that I have agreed to the terms of this document

______________________________	__________________________________	__________
Printed name of minor client	Signed name of minor client	Date

My signature indicates that I have participated in the development of this plan and witnessed the above signatures

________________________________	_________________________________	__________
Printed name of therapist	Signed name of therapist	Date