Client #:_______________________

Options
Counseling and Family Services

INFORMED CONSENT FOR TREATMENT

Permission to Evaluate and Treat

I authorize the staff of Options Counseling & Family Services to complete a mental health assessment and provide mental health treatment and counseling in response to my request for services. My request for mental health services at Options is voluntary. I may ask questions about my treatment at any time and I may stop my treatment at any time. I understand that the mental health assessment that I am consenting to receive is not the same as a psychological evaluation, my mental health provider is only providing evaluation for the purposes of treatment and not to meet any legal purpose.

I acknowledge that Options offers a range of services including individual therapy, family therapy, group therapy, psychiatric services including assessment and medication management, case management, consultation, skills training, and caregiver peer support. Services at Options may be office, home or community based.

I understand that all services are intended to address an identified behavioral health condition and that services are expected to assist me in making improvements to that identified behavioral health condition. I understand that the services offered to me will be based on my medical need and specific behavioral health condition.

By initialing I agree that I have read and understand this section:

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Client Initials

Children 14-17

If I am between the ages of 14-17, I understand that I have the right to start mental health treatment without consent from my parent or guardian. I understand that Oregon law requires that my parent or guardian is involved before the end of treatment unless they refuse or there is a safety reason or concern that they should not be involved. I understand that although my parent or guardian may not be actively involved in my treatment, my parent or guardian may have access to my record unless there is a safety concern which would prevent this access. This reason will then be documented in my record.

By initialing I agree that I have read and understand this section:

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Client Initials

Child and Family Clients:

If I am the parent or guardian of a child client, I understand that my child is the client. I also understand that I am an important part of my child's treatment and will be participating in that process. If my own mental health concerns emerge during that process, I may be supported to seek therapy services for myself.

By initialing I agree that I have read and understand this section:

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Client Initials

Outcome Measure

For the purpose of monitoring and improving services, I acknowledge that I may be asked to fill out questionnaires related to my symptoms and how I feel my treatment is progressing. Information from the questionnaires may help me and my provider monitor improvement and make adjustments in the treatment plan if necessary. I understand that my personal information is kept strictly confidential.
I understand that I may refuse to participate at any time.

By initialing I agree that I have read and understand this section:

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Client Initials

Client #:________________________

INFORMED CONSENT FOR TREATMENT

Individual Rights

I acknowledge that I have certain rights when receiving evaluation or treatment, including:

1. To be treated with dignity and respect.
2. To choose from appropriate services and supports that are consistent with the Service Plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to myself/my child's liberty.
3. To participate in the development of a written Service Plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs.
4. To have all services explained, including expected outcomes and possible risks.
5. Confidentiality, and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, and 414.679, 42 CFR Part 2 and 45 CFR Part 205.50.
6. To be given written informed consent before the start of services, except for a medical emergency or as permitted by law. If you are under 18, you may give informed consent if you are lawfully married, at least 16 and emancipated by the court, or 14 or older, for outpatient services only.
7. To have access to my own record and the right to amend or correct my record.
8. To refuse to participate in experimentation.
9. To receive medication specific to my diagnosed clinical needs, as appropriate to treat my diagnosis, and as available to me.
10. To receive prior notice of service conclusion or transfer, unless the circumstances necessitating service conclusion or transfer pose a threat to health and safety.
11. To be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation.
12. To have religious freedom.
13. To be free from seclusion and restraint. Options providers do not use protective holds, or other methods of isolation or hands-on safety interventions.
14. To be informed at the start of services, and periodically thereafter, of these rights.
15. To be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative assist with understanding any information presented.
16. To have family involvement in your service planning and delivery, if you choose.
17. To make a declaration for mental health treatment, if I am legally an adult.
18. To file grievances, including appealing decisions resulting from the grievance.
19. To exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules.
20. To exercise all rights set forth in ORS 426.385 if I am committed to the Oregon Health Authority, http://www.oregonlaws.org/ors/426.385.
21. To be notified in a timely manner of appointment cancellations.
22. To exercise all rights described in this document without any form of retaliation or punishment.

By initialing I agree that I have read and understand this section:

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Client Initials

INFORMED CONSENT FOR TREATMENT

Client Grievance Procedure

I understand that complaints may be made verbally (the receptionist may direct you to the right person) *or* in writing. Forms are available at the front desk. I understand that I have the right to have assistance in filing a complaint.
You are encouraged to start with Step One and progress to the next step(s) as necessary until the matter is resolved:

1. Discuss concerns with your provider.
2. Discuss concerns with your provider's supervisor.
3. Discuss concerns with the Clinical Manager/ Regional Director
4. Discuss concerns with the CEO of Options.

I acknowledge that I may also make a complaint to the Coordinated Care Organization[1], Oregon Health Authority's Addiction and Mental Health Division, or Disability Rights Oregon, and that information about how to make a complaint is also available in the waiting areas or from any Options employee.

An Options staff member will respond to your complaint within five business days. You may request an accelerated response if you or your child's health is at risk. Expedited complaints will be reviewed immediately (same day) and a decision to shorten the timelines of the process will be made as soon as possible. You will not be denied service or otherwise be discriminated against or experience retaliation because a complaint has been made by you or on your behalf.

To contact the County or Coordinated Care Organization where you receive treatment:

- In **Clackamas County** at (503) 742-5335 or in writing at:
  Clackamas County Behavioral Health Division
  2051 Kaen Road, #367, Oregon City, OR 97045
  Fax: (503) 742-5304

- In **Lane County** at (541) 682-7584 or in writing at:
  Trillium Community Health Plan / Lane County Quality Improvement Coordinator
  P.O. Box 11756, Eugene, Or 97440-3956

- In **Marion County** at (503) 361-2647 or in writing at:
  Mid-Valley Behavioral Care Network
  Quality Improvement Coordinator
  550 Hawthorne Ave SE, Suite 140, Salem, OR 97301

- In **Multnomah County** at (503) 988-5887 or in writing at:
  Quality Management Committee
  Multnomah County MHASD
  421 Oak Street Suite 520, Portland, OR 97204-1620

- In **Washington County** at (503) 846-4554 or in writing at:
  Washington County Health and Human Services
  155 N. First Avenue, MS #70, Hillsboro, OR 97124

By initialing I agree that I have read and understand this section:

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Client Initials

[1] A coordinated care organization (CCO) is a network of all types of health care providers. This may include physical health care, addictions and mental health care, and sometimes dental care providers. These providers work together in their local communities to serve people who receive their health care coverage through the Oregon Health Plan (OHP).

Client #:________________________

INFORMED CONSENT FOR TREATMENT

Risks & Benefits

By agreeing to receive services from Options Counseling & Family Services, I acknowledge that the risks and benefits of treatment have been discussed with me. The risks and benefits of treatment include, but are not limited to, the following:

Benefits

- Determining my strengths and goals for treatment
- Choosing which goals are priorities and working with my therapist in deciding how to reach those goals
- Having the opportunity to become more independent
- Enjoying increased satisfaction with the quality of my life
- Developing a personalized plan to address safety or crisis situations
- Experiencing an increase in positive responses to difficult situations
- Improving my coping abilities and reducing my stress
- Improving my personal relationships

Risks

- Experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, loneliness and helplessness
- Being in touch with painful emotions, sometimes for the first time, which may temporarily lead to feeling worse
- Recalling or talking about unpleasant aspects of my life, which can bring up uncomfortable feelings
- Personal growth sometimes requires changes that may be uncomfortable or unexpected
- Significant others may notice the changes I make; my relationships with others may be affected by the changes I make
- I may not achieve my desired level of improvement.

By initialing I agree that I have read and understand this section:

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Client Initial

I understand that I have the right to refuse or stop treatment at any time. I understand that refusal or stopping treatment may have an effect on my condition, it may worsen, stay the same, or get better.

My signature indicates that I have read and understand/agree to the provided policies, which will be used while I or my family member is in treatment. **I have been offered a copy of my rights, and they have been verbally explained to me.** I have had the opportunity to ask questions. I give permission to Options Counseling & Family Services to provide outpatient behavioral health treatment to me or my family member.

____ _______________________

Signature of Individual (or Parent/Guardian if applicable) Date

____ _______________________

Signature of Provider Date