**New Horizons Mental Health Services**
# INFORMED CONSENT FOR TREATMENT

Today's Date: Client Name: Date of Birth:

## ACKNOWLEDGMENT OF CONSENT FOR TREATMENT

1) I agree to receive ☐ Mental Health and / or ☐Alcohol and other Drug treatment offered by New Horizons for:
   ☐Myself ☐My child ☐The person for whom I am legal guardian
2) I give consent for the use of my Protected Health Information for treatment, payment and health care operations as described in the Notice of Privacy Practices.
3) I acknowledge this consent is voluntary.
4) I further acknowledge that I may revoke, in writing, this consent at any time; except to the extent that action based on this consent has already been taken.

______________________________
Client/Guardian Signature

______________________________
Date

______________________________
Staff/Facilitator Signature

______________________________
Date

I have received a copy of the Client Handbook → Client initials ________
I have declined a copy of the Client Handbook → Client initials ________
I received a copy of the Client Rights Statement at my annual redetermination →Client Initials __________

I understand that if at any time I decide to withdraw my consent for treatment I can ask front office staff or my provider for the Withdrawal of Consent for Treatment form.

If questions, I may discuss with my clinician, or obtain the Handbook at any time during my course of treatment.

☐Myself, being a minor 14 years of age or older → *Clinical Director prior-approval is required before first appointment is scheduled. Treatment will not exceed thirty (30) days or six (6) sessions, whichever occurs sooner. Treatment does not include Pharmacotherapy.*
**Clinical Director Signature** ________________________________ Date _______________

**CLIENT HANDBOOK** includes information about:

- Crisis Intervention
- Special Treatment Conditions Concerning:
  - Risk of Harm to Myself or Others
  - Child and Older Adult Abuse
- My Individual Treatment Process
- Clinical Treatment Process
- My Rights, Responsibilities and Satisfaction
- Benefits and Risks of Treatment and Services
- Privacy Policies
- Safety Practices on Agency Premises
- Various Health Information
- Community Resources Available

1/22/07(Rev 6/21/07ABM 10/30/07, Rev 1/15/08, 7/2/08 JA, 7/31/08, 8/21/08, 6/18/09), 1/19/11 JA

New Horizons Mental Health Services

Today's Date:____________ Client Name:__________________________ Date of Birth:_________________

## CONSENT TO RECEIVE EMAIL/TEXTS

New Horizons may use texting or email as a way to schedule or confirm appointments or to arrange transportation. Please be aware that email and texting should be used for appointment management only. These forms of digital communication should never contain confidential, clinical information or be considered treatment. Texting is not an appropriate way to reach out for help during a crisis or emergency situation. If you are experiencing an emergency please contact 911 or the Crisis Talk Line at (740) 687-8255.

I give my permission for communication by email/texting, understanding the limits of protection using such electronic means. I understand that I may revoke my authorization at any time, except to the extent that action will have been taken prior to the revocation of my consent. Otherwise, this authorization is valid for the duration of my treatment at New Horizons.

Email Address: ______________________________________________________________

Cell Phone Number: ________________________________ Cell Phone Provider: ____________________

_________________________________________ ___________________________

Client/Guardian Signature Date

_________________________________________ ___________________________

Staff Signature Date

## REVOCATION OF CONSENT

I wish to revoke my consent.

_________________________________________ ___________________________

Client/Guardian Signature Date

_________________________________________ ___________________________

Staff Signature Date

## Telehealth Informed Consent and Privacy Acknowledgement

We are able to offer you our services through a Telehealth option when you are not able to come on site or be otherwise available for face-to-face services with our agency. This option would allow you to community with your provider remotely through technology instead of in person. On your end this could be via a computer or laptop with camera and microphone, a tablet connected to the Internet, or a smart phone with a camera. Telehealth could also involve communicating by audio only with a telephone when video is not possible.

Expected benefits for using Telehealth/telephone sessions: Improved access to behavioral healthcare services. You can remain in your home or other chosen site for safety and health reasons and still receive a remote service with your provider. This also reduces travel time for appointments, allowing you more flexibility to fit them in your day.

Possible risks in using Telehealth/telephone sessions: As with any healthcare procedure, there are potential risks associated with the use of Telehealth. These include but may not be limited to: In rare cases, information transmitted may not be sufficient (example, poor resolution images or voice) to allow a complete session. Delays in treatment could occur due to deficiencies or failures of the equipment; in very rare instances security protocols could fail, causing a breach of privacy of personal information (as with traditional face-to-face services). In case we get disconnected or you are in crisis, we will ask you for a phone number and your current location and address at the beginning of the session. You can also call us back at the number(s) listed below if disconnection occurs.

To protect your privacy, we will never record Telehealth sessions (unless it has been previously agreed to by all parties for a specific reason), will use a video platform that is secure and encrypted, and will start each session with security questions to confirm your identity and contact information.

Our New Horizons Mental Health Services Privacy Policy (in the Client Handbook) and Informed Consent for Treatment applies to all services in all forms of delivery. The laws that protect privacy and the confidentiality of health information also apply to Telehealth, and no information obtained in the use of Telehealth which identifies you will be disclosed to other entities without your consent.

You have the right to withhold or withdraw your consent to the use of Telehealth services in the course of your care at any time without affecting your right to future care or treatment.

By signing below (or verbal verification when signature is not possible), you are verifying that you understand your privacy rights in regards to telehealth, you understand the benefits and risks, and you consent to participate.

_________________________________________ ___________________________

Client/Guardian Signature Date

_________________________________________ ___________________________

Staff Signature Date

## New Horizons Mental Health Services

| 230 N. Columbus St. Ste. 2 | 437 Hill Road North | 2652 Kull Rd. | 2660 & 2680 Kull Rd. | 1550 Sheridan Dr Ste. 202. |
|---|---|---|---|---|
| Lancaster, Ohio 43130 | Pickerington, Ohio 43147 | Lancaster, Ohio 43130 | Lancaster, Ohio 43130 | Lancaster, Ohio 43130 |
| p-740.901.3150 | p-614.834.1919 | p- 740.277.6733 | p-740-277-6166 | p-740-808-8371 |
| f-740.808.8172 | f-614.834.1920 | f- 740.277.7020 | f- 740-277-6700 | f- 740-785-4924 |


**Authorization to Use and Disclose Confidential Protected Health Information** [3793:2-1-06(H)]

Regarding: **CLIENT NAME**________________________________________ **DOB** ____________ **ID#**______________

______________________________________________________________________________________________

**Name of Physician** **Address** **Phone** **Fax**

**The above named may ☐ disclose to, or ☐ receive from, or ☐ exchange information with:** The above listed New Horizons locations.

**Purpose of Disclosure**:
☐ Continuity of Care ☐ Disability Determination ☐ Ongoing Treatment ☐ Treatment Planning with Client
☐ Other Purposes (Specify): ________________________________________________________

**Description of Information to be Disclosed**:
☐ Attendance ☐ Crisis Assessment ☐ Diagnosis-Diagnostic Assessment ☐ HIV/AIDS Test Results or Status
☐ Laboratory & Medication Results ☐ Physician's Orders/Medical Notes ☐ Pregnancy Test Results
☐ Prenatal Care Received ☐ Progress In Treatment ☐ Psychiatric Evaluation ☐ Psychological Evaluation
☐ Information on Mental Illness and/or Treatment ☐ Urine Testing Entire Medical Record
☐ Other Information (Specify): ________________________________________________________

**Amount of Information to be Disclosed**:
☐ Previous Three Months ☐ Previous ___ year(s) ☐ Most Recent Admission or Episode of Care

☐ Other (Specify) ________________________________________________________________

*I understand this authorization remains in effect until the date of expiration. I understand this authorization may be withdrawn any time in writing (except to the extent that action has already been taken). Further release shall cease (except as allowed by law) upon New Horizon's receipt of the written revocation. I also understand that the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. The health care providers listed above will not receive financial or in-kind compensation in exchange for using or disclosing my health care information.*

**Indicate only one of the following:**
☐This authorization will expire upon the termination of treatment & services at New Horizons Mental Health Services
☐This authorization will expire when (condition) ______________________________________________
☐This authorization will expire on (date) _______/_______/_______

**Signature of Client/ Guardian** ________________________________________ **Date** ________________

**Staff Signature and Title** ________________________________________ **Date** ________________

**Provider: Please check box if you would like a request for records sent**

NOTICE TO RECIPIENT OF PROTECTED HEALTH INFORMATION Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal ru les restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 and 164. These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.

## NOTICE OF REVOCATION

**Client Name** ________________________________________ **ID#** ______________

**I revoke authorization for further use and disclosure of my protected health information effective:**

**Date Revoked**______________

**Signature of Client/Guardian** ________________________________________ **Date** ______________

**Staff Signature and Title** ________________________________________ **Date** ______________