Consent To Receive Services/ Acknowledgment of Grievance/ Rights of Individuals Receiving Services

Community Counseling Services Rev 01/17

Case Name ______________________________

Case Id. # ______________________

Date ______________

Consent To Receive Services

The information which I have provided as a condition of receiving services is true and complete to the best of my knowledge. I consent to receive services as may be recommended by the professional staff. I understand the professional staff may discuss the services being provided to me, and that I may request the names of those involved. I further understand that my failure to comply with therapeutic recommendations of the professional staff may result in my being discharged.

I understand that I have the freedom of choice to receive services in a setting that is integrated in and supports full access to the greater community; and is a setting that facilitates individual choice regarding services and supports, and who provides them.

I understand that State and Federal laws and regulations prohibit any entity receiving confidential information from redistributing the information to any other entity without the specific written consent of the person to whom it pertains or as otherwise permitted by law and regulations.

I understand that I am responsible for payment of services at the time that the services are rendered. I understand that a return appointment will be made only if I have no outstanding balance, unless prior arrangements have been made on the account. I understand that I must be the parent or legal guardian in order to consent to treatment for a minor child. I also understand that information regarding a minor child may be released to either parent, whether custodial or not, upon request.

I understand that confidential information may be released without my consent when necessary for continued treatment; when release is necessary for the determination of eligibility for benefits, compliance with statutory reporting requirements, or other lawful purposes; if you communicate to the treating physician, psychologist, master social worker or licensed professional counselor an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims; in compliance with reporting requirements under state law of incidents of suspected child abuse or neglect or by court order.

I have been informed of, understand and acknowledge that I have received a written copy of the above information and give my consent to receive services from this agency. I also acknowledge that I have received a copy of the notice of privacy practices.

_____ Individual/Legal Representative Initials

ACKNOWLEDGMENT OF GRIEVANCE:

I have been informed and given a copy of the policies and procedures for reporting a complaint or grievance concerning any treatment or service that I receive.

_____ Individual/Legal Representative Initials

RIGHTS OF INDIVIDUALS RECEIVING SERVICES:

I, ____________________________ began receiving services provided by COMMUNITY COUNSELING SERVICES on
Name *Name of Provider*

______________________ and have been informed of the following:
Date of Admission

1. My options within the program and of other services available
2. The program's rules and regulations
3. The responsibility of the program to refer me to another agency if this program becomes unable to serve me or meet my needs
4. My right to refuse treatment and withdraw from this program at any time
5. My right not to be subjected to corporal punishment or unethical treatment which includes my right to be free from any forms of abuse, neglect, exploitation or harassment and my right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff
6. My right to voice my opinions, recommendations and to file a written grievance which will result in program review and response without retribution
7. My right to be informed of and provided a copy of the local procedure for filing a grievance/complaint at the local level or with the DMH Office of Consumer Support
8. My right to privacy and confidentiality in respect to facility visitors in day programs, residential treatment programs and community living programs as much as physically possible
9. My right regarding the program's nondiscrimination policies related to HIV infection and AIDS
10. My right to be treated with consideration, respect, and full recognition of my dignity and individual worth
11. My right to have reasonable access to the clergy and advocates and have access to legal counsel at all times
12. My right to review my records, except when restricted by law
13. My right to fully participate in and receive a copy of my Individual Service Plan/Plan of Care and Supports or Activity Plan. This includes: 1) having the right to make decisions regarding my care, being involved in my care planning and treatment and being able to request or refuse treatment; 2) having access to information in my clinical records within a reasonable time frame (5 days) or having the reason for not having access communicated to me; and, 3) having the right to be informed about any hazardous side effects of medication prescribed by staff medical personnel
14. My right to retain all Constitutional rights, except when restricted by due process and resulting court order
15. My right to have a family member or representative of my choice notified should I be admitted to a hospital
16. My right to receive care in a safe setting
17. My right to confidentiality regarding my personal information involving receiving services as well as the compilation, storage, and dissemination of my individual case records in accordance with standards outlined by the Department of Mental Health and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if applicable

Additionally, rights for individuals in supervised and residential treatment/living arrangements:

18. My right to be provided a means of communicating with persons outside the program
19. My right to have visitation by close relatives and/or significant others during reasonable hours unless clinically contraindicated and documented in my case record
20. My right to be provided with safe storage, accessibility, and accountability of my funds
21. My right to be permitted to send/receive mail without hindrance unless clinically contraindicated and documented in my case record
22. My right to be permitted to conduct private telephone conversations with family and friends, unless clinically contraindicated and documented in my case record

Release of information without consent: This service provider/program/facility/agency may, without consent, divulge information and/or contact a third party(ies) regarding the individual receiving services if there is indication, by work or action, that he/she (1) is , or recently has been abusing a child, or has been abused; (2) intends to physically harm another person (3)intends to physically harm themselves (4) is unable to provide for his/her own physical safety, including but not limited to, a Medical emergency; or (5) if necessary for the continued treatment of the individual receiving services or (6) in the case of marital/couples counseling, information in the chart cannot be disclosed without the written consent of both parties.

Court Order Process: Written information/materials regarding the individual receiving services are subject to Court Order. Should a court order all or any portion of the case records of the individual receiving services, this service provider/agency will submit them to the court.

I have been informed of, understand and have received a written copy of the above information.

____ ____

Individual Receiving Services Date Legal Representative Date

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Staff/Credentials Date