

## **Behavioral Health: Client/Patient Consent**

***Commitment to Diversity, Equity, Inclusion, and Justice:*** The CrescentCare Mission to offer comprehensive health and wellness services to the community, to advocate empowerment, to safeguard the rights and dignity of individuals, and to provide for an enlightened public leaves no room for racism or intolerance of any kind. We have zero tolerance for any language or action that are racist or intolerant. Any racist or intolerant language or action is considered a violation of the “client/patient responsibilities” detailed in the CrescentCare Patient & Client Handbook—inappropriate behavior has consequences that will be addressed by CrescentCare staff. We thank you for joining us in this commitment to our community!

\_\_\_\_\_ ***Consent for Behavioral Health Care Services:*** I understand that by signing below I give CrescentCare’s Behavioral Health Program my consent for behavioral health treatment, which expires when I withdraw this in writing or upon discharge from the program. That treatment may include, but is not limited to assessment, evaluation and counseling, psychological testing, laboratory procedures, psychotropic medication, and/or televisits, rendered to me voluntarily under the general and specific instruction of CrescentCare, my provider or his or her attending or collaborating physician. I am aware that the practice of medicine and psychotherapy are not exact sciences, and I acknowledge that no guarantees have been made concerning the results of my care at CrescentCare centers. I also consent, if applicable, to following the requirements listed in the Controlled Medication Agreement and have been offered a copy of that document. I can ask for another copy at any time or find it on the CrescentCare website.

\_\_\_\_\_ ***Consent for Billing and Financial Obligations:*** If private health insurance, Medicare, Medicaid, other governmental or other insurance programs cover my treatment, I authorize CrescentCare to bill any such insurer for all charges incurred by me in connection with my diagnosis, care and treatment. My insurance coverage may provide that some amount of the bill will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered by my health insurance, Medicare, Medicaid or any other programs for which I am eligible. I understand that will be billed for any charges not paid by my insurer, and I will be responsible for paying them. CrescentCare’s policy is to provide essential services regardless of my ability to pay. CrescentCare utilizes sliding fee schedules for services it provides that are consistent with locally prevailing rates or charges and which are designed to cover the reasonable costs of the organization’s operation. When I am referred to an outside provider, I must make payment arrangements with them separately. If I have any questions about the sliding fee scales or billing, I can contact CrescentCare by emailing [billing@crestcentcare.org](mailto:billing@crestcentcare.org) and/or by calling the Billing Department at 504-323-2641.

\_\_\_\_\_ ***Confidentiality & Limits:*** CrescentCare is committed to protecting my privacy. Confidential information will be revealed only with my written consent, if my safety or the safety of someone else is imminently threatened, or if a court orders that my information be released. State law requires that information may only be released in these specific instances:

- If I am in serious danger of harming myself or if I am at serious risk for harming another person
- If abuse or neglect of a child, an elderly person, or a disabled person is reported
- In the event of a court order compelling the release of my clinical record to a court of law
- Reporting a Therapist or Psychiatrist to her/his professional licensing board for engaging in a sexual relationship or asking to have a sexual relationship with me

\_\_\_\_\_ ***Conflict of Interest & Dual Relationships:*** Your relationship with your provider is a professional relationship and CrescentCare providers will not engage in shared activities with you outside of treatment. While it could seem impolite, in order to protect your privacy, your provider will not approach/acknowledge you if they should come into contact with you outside of CrescentCare unless you choose to acknowledge them first. It could happen that you are not comfortable with your behavioral health provider. If you feel like you can and want to discuss this with your provider, we welcome this feedback. If you would rather speak to someone else about this, please contact a behavioral health supervisor or another trusted member of your care team so that we can connect you with a behavioral health provider you are comfortable with. You can also contact the Compliance Department by calling our main desk or sending an email to [compliance@crestcentcare.org](mailto:compliance@crestcentcare.org).

\_\_\_\_\_ ***Risks & Benefits:*** Behavioral health treatment has both benefits and risks. Risks may include uncomfortable feelings because the process often requires discussing difficult aspects of one’s life. Benefits include significant reduction in feelings of distress, increased satisfaction in relationships, greater awareness and insight, and improving coping strategies and problem-solving skills.

\_\_\_\_\_ ***Team Approach:*** CrescentCare Behavioral Health providers work closely with your primary care provider and case management team to ensure your care is coordinated. Your CrescentCare team’s goal is to provide you with a personalized support network where you and all of your providers collaborate in the treatment process to achieve your desired results. I authorize CrescentCare providers and staff involved in my care to access my medical

record and discuss my medical conditions, including any substance abuse treatment I may receive at CrescentCare with each other and others, as appropriate, in the furtherance of providing me quality health care.

**Appointment Policy:** Sessions with a therapist are typically 45-50 minutes unless otherwise discussed. The length of visits with a psychiatrist varies and is generally 30-60 minutes. Please be on time; your provider may re-schedule your visit if you are more than 15 minutes late to your appointment. If you miss three consecutive scheduled appointments for a psychiatric evaluation or for therapy, you may be referred to an outside provider. An appointment is considered “missed” if you don’t notify your provider that you cannot attend an appointment at least one business day prior to the appointment. The intention is not to penalize you, rather it is to make these services available to others in need.

**Treatment Planning/Goal Setting:** Treatment typically begins with an assessment at your first appointment. The purpose of the assessment is to understand your physical, emotional & mental health, self-perception, and how you function in your community. You and your provider will create your goals for treatment, also called your treatment plan. This is your road map for treatment—it’s how you and your provider can measure your progress and set a rough timeline for treatment. Therapy is meant to be a time-limited process; the goal is for you to develop the skills or make the changes that allow you to lead a healthy life without therapy.

**Termination & Transitions:** It’s normal to feel reluctant to end therapy—we’ll talk about what will help you to feel ready to end therapy and maintain your achievements. Ending therapy may involve a “fading-out” approach where the frequency of sessions is gradually reduced. We will create a behavioral health maintenance plan that will help you remember the self-care, coping strategies, and social support that will help you with ongoing challenges you might face—and even to recognize when it might benefit you to return to therapy. You may also choose to self-terminate prior to accomplishing your goals. Your provider can also talk with you if you want to end treatment prior to accomplishing all of your goals—we can help you plan for the support you feel you need. If we do not hear from you for 3 months, we’ll close your case and you can contact us if you want to come back to treatment. We may not be able to re-start therapy immediately, but we will help to connect you to support.

**Support System Involvement:** We encourage the appropriate involvement of your support system in your care. Please talk with your provider about how your support system can be involved in your care.

**Telehealth:** If you have a telehealth visit, please treat this visit as much like an in-person visit as possible. It’s important to be in a quiet & private space, to be on time, and to talk to your provider about a back-up plan if there are technical problems.

**Communication:** You agree to receive communications from CrescentCare from time to time, including mail, e-mail, phone calls or text messages related to billing, care and treatment, appointment reminders, and quality of care surveys. It is your responsibility to tell the Agency about any method that I don’t want to receive.

**Receipt of Documents:** You received the *CrescentCare Notice of Privacy Practices (HIPAA)* and *CrescentCare Patient & Client Handbook*. when you enrolled at CrescentCare. These documents contain detailed information on payment/financial agreements for services, use of health insurance, confidentiality, all CrescentCare services available, your rights and responsibilities, safety on the premises (drug use, weapons, smoking, seclusion/restraint, crisis prevention, evacuation), our grievance policy, how we communicate with you about appointments, payment practices, and our locations/hours of operation. You can obtain another copy of these documents on the CrescentCare website or at any of our locations.

**Acknowledgment:** My signature below constitutes my acknowledgment and agreement that I have read and understand the above, was given the opportunity to discuss this form and ask questions, that all questions were answered to my satisfaction, and I am satisfied I understand the form’s contents and significance.

**I certify that I have read the foregoing (or had it read to me), and either am a patient or am duly authorized by law to execute the above and accept the terms.**

\_\_\_\_\_  
Signature of Patient or Authorized Individual

\_\_\_\_\_  
Date

If Authorized Individual, please provide name and relationship to patient:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship