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 42 C.F.R. Part 2, Connecticut General Statutes 17a-540 et seq., the Connecticut licensing regulations for Licensed Psychiatric Outpatient Clinics for Adults and Licensed Psychiatric Outpatient Clinics for Children and Adolescents, Joint Commission Standards, and Community Health Center, Inc. policies. Community Health Center, Inc.'s HIPAA Notice of Privacy Practices was provided to you at the time of your registration as a client and is also available online at https://www.chc1.com/Privacy-Statement.

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. Because these are professional records, they can be misinterpreted and/or be upsetting to untrained readers. Therefore, if your provider allows you to review a copy of your treatment records, we recommend that you review them in the presence of your behavioral health provider so that you can discuss the contents. In the event that you need to be referred to a different behavioral health provider, Community Health Center, Inc. is happy to send your treatment records to a mental health professional of your choice. All requests for records will be processed by our Medical Records department within 30 days of the receipt of the request for records.

My rights as a client of CHC Behavioral Health include:

1. To be treated without regard to race, color, religion, sex, gender identity, gender expression, national origin, marital status, sexual orientation, and mental or physical disability.
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 reporters CHC clinical 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. CHC 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.
6. If I am under 18 year of age, I may seek drug or alcohol counseling without a parent's consent. If there is reason to believe that notifying my parent about my seeking treatment would cause me harm or cause me not to seek treatment, I may be seen up to 5 times without a parent's consent upon the approval of my therapist and the Chief Behavioral Health officer or his 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 of the Community Health Center receive integrated care through a shared electronic health record.
9. All CHC offices are open from 8:30 a.m. to 5 p.m. with regular Saturday hours. Most are also open several evenings per week and many open earlier than 8:30. Ask your therapist or other CHC staff for up to date information about the site at which you are being seen. Call the site number for after hour coverage.
10. I have the right to receive services in a language that I understand. When language assistance is required, CHC will provide a language interpreter at no cost to me by using the language assistance sere detailed in CHC's policy. My family members will not be used as interpreters unless I want my family member to provide interpretation services instead of using an interpreter provided by CHC.
11. If I am not happy with any aspect of the care I receive, I may notify my therapist or any other CHC staff member who will be able to help me complete a feedback form for review by administrative staff. I may notify the On Site Behavioral Health Director of any concerns or contact the Chief Behavioral Health Officer, Tim Kearney , Ph.D., at 860-347-6971, Extension 3507 or tim@chc1.com.
12. Each month a number of CHC clients are called by our client satisfaction team, Crossroads, Inc. You have the right to give your opinion freely with or without telling the caller your name or to refuse to participate in the survey.

My responsibilities as a client of CHC 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 CHC sites are tobacco free and weapon free, and refraining from threatening or violent behavior while at CHC.
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 may be unable to schedule further appointments in advance until I have attended at least one group and/or same-day session and will need to contact my therapist. My treatment plan may be revised to replace individual sessions with group sessions and/or same-day sessions. I may also be given the option of a standby appointment, which does not guarantee that I will be seen on the day it is scheduled. Even if I am not seen, I will be taken off of standby status after coming for the scheduled standby appointment.
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 CHC.
7. To arrange for the administration of medications. The behavioral health department of CHC 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 refills 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 CHC Behavioral Health clinical settings. This adult must be available during the treatment in case of emergencies. The therapist and parent/guardian may make other written agreements for drop off and pick up for child clients. This expectation does not apply to parents of children seen in our School-Based Health Centers during the school day when school is in session.
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 a psychiatric advance directive should notify staff of this fact so that it may be recorded in our records.

Patient Notice Regarding
Confidentiality of Substance Use Disorder Patient Records (42 C.F.R. 2.22)

The confidentiality of substance abuse disorder patient records maintained by Community Health Center, Inc. (CHC) is protected by Federal law and regulations.

Generally, CHC may not say to a person outside CHC's program that a patient attends the program or disclose any information identifying a patient as having or having had a substance abuse disorder, unless:

1) The patient consents in writing;

2) The disclosure is allowed by a court order; or

3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suggested violations may be reported to: (1) the United States District Attorney, District of Connecticut, 450 Main Street, Room 328, Hartford, CT 06103, (860) 947-1101, Fax: (860) 760-7979; or (2) to the Substance Abuse and Mental Health Services Administration, Region I, Barbara Howes, Acting Compliance Officer, (240) 276-2547, Barbara.Howes@samhsa.hhs.gov, in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R. part 2 for Federal regulations).

Consent for Treatment, Payment and Healthcare Operations

I give consent for myself (or for my minor child _____) to receive behavioral health services which may include substance abuse treatment services, provided by staff of the Community Health Center, Inc.

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 for treatment at any time by giving written notice to the Community Health Center, Inc.

I also authorize the Community Health Center, Inc. to disclose my substance abuse treatment records: (1) to my insurance company or third party payor (e.g., HUSKY, or private insurance); (2) to other treating providers who are involved in my care; or (3) for the Community Health Center Inc.'s internal or external health care operations needs. I understand that I can request, at any time, a list of entities that received my information. I also understand that if I want to exclude certain substance abuse treatment records from my authorization above, I should make that request here: _____

My consent expires when I no longer receive behavioral health or substance abuse treatment services from Community Health Center, Inc. or when I provide Community Health Center, Inc. with written notice that I am revoking this consent, except to the extent that the Community Health Center, Inc. has taken action on my consent.

_____	_____	_____
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 this document has been discussed with me in age appropriate language. If I chose not to sign and am under 18 years of age, my parent/guardian's signature is legally binding.

_____	_____	_____
Printed name of therapist	Signed name of therapist	Date

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