

Mid-Columbia Center for Living

CONSENT TO TREATMENT, CONFIDENTIALITY and INFORMATION ON SERVICES

Services shall not be denied any person without regard to race, ethnicity, gender, gender identity, gender expression, sexual orientation, religion, creed, national origin, age (except when program eligibility is restricted to children, adults, or older adults), familial status, marital status, source of income, and disability.

I am voluntarily seeking services from the Mid-Columbia Center for Living (MCCFL). I understand that both MCCFL and I have the right to terminate services at any time by simply notifying the other party of this intention. *Additionally, the following infractions may result in termination as well as possible legal action:* Verbal or physical aggression toward staff or property of the MCCFL; and/or theft or vandalism of property of staff or of the Mid-Columbia Center for Living.

I have received the **Notice of Privacy Practices** and understand that MCCFL will keep information about my case confidential, including the fact that I am participating in services, with the following exceptions:

- If a medical emergency occurs, information necessary to help me may be shared with my physician or other medical personnel.
- In a life-threatening situation, information may be released to the appropriate authority.
- MCCFL is legally obligated to report abuse of children, elderly, disabled persons and/or individuals enrolled in our mental health services.
- My case record and/or my counselor may be subpoenaed and information about me disclosed in a court of law.
- Information (for example: age, gender, income, name, etc.) will be sent to the State Office of Mental Health and Addiction Services and Community Development Block Grant office and will be used only for statistical purposes.
- MCCFL may disclose information to other additional parties only when given written permission by me.
- Any exceptions listed in the Notice of Privacy Practices provided to me.
- My case may be discussed with staff members of the MCCFL, State Office of Mental Health and Addiction Services or my Coordinated Care Organization (CCO) (for OHP members only) and subject to audits for assurance of quality or treatment.

ALL CLIENTS: I have been offered a **Medical Advanced Directive** & understand my options for health care treatment.

Clients participating in MENTAL HEALTH SERVICES:
I have received the **Notice of Right to Make a Declaration of Mental Health Treatment** and understand that I may obtain more information on this matter from MCCFL staff, if I am interested.

Clients participating in SUBSTANCE USE TREATMENT SERVICES:
a) Clients are to remain abstinent from alcohol and mood altering drugs. The treatment program may require urinalysis to substantiate this requirement. Attending individual or group sessions while intoxicated is grounds for termination.
b) Fees will be paid at time of service unless otherwise arranged prior to treatment.
c) Clients are responsible for attending sessions as scheduled.

I have reviewed and received a copy and understand my rights and responsibilities.

I understand and agree with the above terms and consent to participate in the services at the Mid-Columbia Center for Living.

Signed: _____ Date: _____
Client

Signed: _____ Date: _____
Parent/Guardian or Personal Representative for Health Care Decisions

For Mid-Columbia Center for Living Use Only: *Client and/or guardian refused to sign consent because:*

Staff signature

Date