Informed Consent

Client Name: _____DOB:_____ Date: _____

The following points are to be reviewed carefully with the client and annually thereafter.

Informed consent is an interactive process involving the client and/or guardian when treatment is ready to begin. Each time a change is made in diagnosis and/or treatment recommendations, the signatures on the informed consent will confirm that informed consent has been reviewed again. The client and family are to be provided with enough time and information to ask questions and make an informed decision.

Check each item as it is discussed with the client and/or guardian:

- ☒ HIPAA Privacy Notification-I understand the limitations on the confidentiality of information (e.g. for abuse, neglect, dangerousness) [Welcome Booklet]
- ☒ Client Rights Statement [Welcome Booklet]
- ☒ Client Responsibilities [Welcome Booklet]
- ☒ Financial Responsibilities [Welcome Booklet]
- ☐ My condition/diagnosis
- ☐ The nature and purpose of treatment
- ☐ The likelihood of success
- ☐ The risks and potential consequences of treatment including refusing treatment and the likely consequences of doing so
- ☐ The alternatives to treatment including refusing treatment and/or medications and the consequences of doing so
- ☐ I have the right to accept or refuse drug testing for illicit substances and understand the consequences of doing so
- ☐ I have the right to include or exclude my family or significant others from services to the extent permitted by law.
- ☐ I understand that any future changes in my treatment recommendations will be discussed with me and will be reflected in my treatment plan.
- ☐ I understand that I must attend my scheduled sessions to remain in services at SCI.
- ☒ SUPR Only: Received HIV/TB Education [Welcome Booklet]
- ☐ I understand that my child(ren) residing with me or visiting me at the Recovery Home are my sole responsibility, and it is not the responsibility of SCI staff to care for my child(ren).
- ☐ SCI will not be held liable for any injury or accident that occurs with my child(ren) while they are under my watch or the watch of my designee at the Recovery Home

Psychiatric Advanced Directive (PAD)

For clients 18 and over being seen for mental health services:
Does the client have a Psychiatric Advanced Directive? ☐ Yes ☐ No
If the client has a PAD, has a copy been obtained for the client record? ☐ Yes ☐ No ☐ N/A
If the client does not have a PAD, were they given information about a PAD and how to obtain one if interested? ☐ Yes ☐ No ☐ N/A

Opioid Education

For clients who have an Opioid Use Disorder: Was opioid education/information provided today? ☐ Yes ☐ No ☐ N/A

Family

Expectation of family regarding their role in the client's treatment: Click or tap here to enter text..
Guardian is aware of role in treatment? ☐ Yes ☐ No ☐ N/A

Technology Expectations and Understanding

1. Please understand that you are responsible for providing the necessary computer, equipment, and internet for the telehealth sessions. If you decide to keep emails or communication on your device, it is up to you to make sure that information is secure.
2. Please understand that there are risks and consequences from telehealth services, despite reasonable efforts of the organization, including the following:
    a. Transmission of information could be disrupted or distorted by technical failures; and/or
    b. Transmission of information could be interrupted by unauthorized persons or accessed by unauthorized persons.
3. It is your responsibility to make sure your location, device, and internet connection are secure.

Employee signature indicates that the client's rights have been reviewed with the client and the employee believes that the client understood these rights.

This is to consent to treatment provided by Sinnissippi Centers, Inc. (SCI). I also authorize SCI to release information from this client service record, including my social security number, as is required to pursue, receive, and/or determine payment or reimbursement for any billings related to my assessment and/or treatment services, including alcohol and drug abuse records protected under federal legislation, and disclosure of my social security number pursuant to federal regulations, 42 U.S.C. Section 405(c)(2). I assign to and for payment directly to SCI, third party payer benefits due me. I understand that SCI reserves the right to use established collection procedures if I do not meet my payment responsibilities. I also understand that procedures include payment of all costs of collection, including but not necessarily limited to reasonable attorney's fees incurred by SCI in enforcing collection of this obligation. I also understand that interest will accrue at the rate of 12 percent per annum on any unpaid balance.

Signature: (Client) _____ Date: _____

Signature: (Guardian) _____ Date: _____

Signature: (SCI Employee) _____ Date: _____