

# County of San Luis Obispo Behavioral Health Department

## CONSENT FOR BEHAVIORAL HEALTH TREATMENT

### Drug & Alcohol Services and Mental Health Services

2180 Johnson Ave, San Luis Obispo, CA 93401 Phone: (800) 838-1381 FAX: (805) 781-1177

### Consent for Behavioral Health Treatment:

I give consent for the County of San Luis Obispo Behavioral Health Department (SLOBHD) to provide medically necessary behavioral health services to me or to the client identified on this Consent for Treatment.

### My Rights:

I understand that I have the right to:

- Discuss treatment options with my providers. SLOBHD staff will discuss all treatment procedures, including medication, observed urinalysis for drugs of abuse, patching, and breathalyzer, with me.
- Ask for and get information about risks, benefits, and alternatives to each service
- Help develop and receive a copy of my treatment plan
- Receive professional care. I understand that results are not guaranteed.
- Be treated with dignity and respect
- Refuse or discontinue any service or procedure. If a court ordered me to be in treatment, I understand that I may still refuse to participate, even though I may face legal consequences for my choice. For minors or conserved adults, the legal guardian has the right of refusal, unless the minor, aged 12 or above, consented or could have consented to his/her own care.

### My Responsibilities:

I understand that I am responsible to:

- Keep my appointments, which will help me benefit the most from my treatment. If I fail to keep appointments, SLOBHD may stop my services.
- Conduct myself in an appropriate and respectful manner. If I am aggressive, violent, or threatening to staff or clients, SLOBHD will contact law enforcement. Charges may be filed.
- Protect the confidentiality of other clients. If I violate other client's confidentiality, SLOBHD may stop my services.
- Participate in treatment

### Payment/Billing Authorization:

- I hereby authorize SLOBHD to bill for all services provided to me. I authorize SLOBHD to receive payment of medical benefits from any health insurance plan(s) that cover me, including Medi-Cal, Medicare, and private health insurance.
- I understand that if I have full scope Medi-Cal coverage, SLOBHD will not charge me for the services that I receive, as long as my Medi-Cal coverage is active. If I do not qualify for or if I lose Medi-Cal eligibility, I must pay for my services. If I must pay for services, SLOBHD staff will discuss a reasonable payment schedule with me

**Informing Materials:**

I understand that the Medi-Cal Beneficiary Handbooks are available at the following locations:

- <http://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Forms-Documents/Client-Informing-Materials- Handbooks.aspx>
- Upon request at any Behavioral Health Clinic

I understand that the Provider Lists are available at the following locations:

- <http://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Forms-Documents/Quality-Support-Team/Network-Provider-List.aspx>
- Upon request at any Behavioral Health Clinic

**I received a copy of the following:** (Check all that apply)

- Consent for Behavioral Health Treatment (required for all services)
- Information about Advanced Directives (required for mental health services)

In addition, for Drug & Alcohol Services:

- Client Handbook

The Client Handbook contains information about:

- HIV/AIDS, Hepatitis C, TB Information sheet and phone numbers for testing and referrals
- Information about drug testing, including what I may or may not take while testing
- Information about services, payment, expected behavior, what I can do if I relapse, and general community resources
- Information about Recovery Support Services and after care follow up options

**Right to Withdraw Consent for Behavioral Health Treatment:**

I understand that this Consent for Behavioral Health Treatment is effective for the duration of my treatment at SLOBHD unless I withdraw it by telling SLOBHD staff. My signature or the signature of a guardian in my place indicates that this consent form has been explained to me in a language that I can understand, and that I (or my guardian) agree(s) with the above.

Is the client willing and able to sign the agreement

- Yes
- No If no, explain:

\_\_\_\_\_  
Signature of client:

\_\_\_\_\_  
Date:                      Time:

\_\_\_\_\_  
Signature of legally responsible person (if needed)

\_\_\_\_\_  
Date:                      Time:

\_\_\_\_\_  
Staff Witness

\_\_\_\_\_  
Date:                      Time: