Consent for Treatment Services

Individual's Name: **DOB:**

The Multnomah County Behavioral Health Division (BHD) provides mental health services, which may include: assessment; level of need determination screening; observation; consultation; environmental intervention; individual, group, and family treatment or care coordination; case management; child and family team meetings; crisis services; and/or information and referral for mental health services or screening and referral only. Services may be provided in person, over the telephone, or via telemedicine.

RISKS AND BENEFITS

The goal of mental health treatment is to decrease targeted mental health symptoms. There are some risks to treatment:
Symptoms can worsen before they improve or may persist even after treatment is complete. New symptoms or treatment issues may emerge during the course of treatment. Progress related to mental health symptoms or issues can result in changes that have the potential to disrupt life patterns or interpersonal relationships. Psychiatric medication, if prescribed, can have side effects that may need monitoring or management.

There are also benefits to treatment:
Individuals participating in mental health treatment often learn skills to help cope with difficult emotions, change destructive patterns of thinking, improve interpersonal communication and positively impact overall behavior and personal wellness.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I certify that I have received the following written information and that it has been explained to me:
If you have not been given the opportunity to review these documents or need them in a different language, please contact your clinician or a Behavioral Health Division employee.

- A description of my, and/or my child's, individual rights as a client of Multnomah County BHD.
- Notice of Privacy Practices (NOPP). The NOPP describes the privacy and confidentiality practices of Multnomah County Health Department and that of BHD.
- BHD's Complaint (Grievance) Brochure and Form. I also understand that if I am dissatisfied with services, I may initiate a complaint/grievance verbally or in writing with any staff member or through my services, I may initiate a complaint/grievance verbally or in writing with any staff member or through my representative.
- **For clients 18 and over only:** I have been offered information about how to complete a Declaration for Mental Health Treatment.
- **For clients 17 and over only:** I have been offered information about voter registration.
- **For parents or legal guardians:** I have been informed and agree that Multnomah County BHD staff may coordinate with the individual directly in person; via telephone, email, or video.

Insurance Coverage Information
Federal law requires that if your or your child's mental health services are covered by the Oregon Health Plan, all reasonable efforts will be made to ensure that the Oregon Division of Medical Assistance Programs (DMAP) will be the payor of last resort. If you or your child are covered by commercial insurance or any other source of payment, you may be asked to sign an authorization to bill for these services. Your ability to pay will not prevent you from receiving services.

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Estimate of Charges

This Good Faith Estimate is valid until services are terminated. Regardless of your insurance status, type, or coverage, it is the policy of Multnomah County Behavioral Health Division to never bill you for services.

Primary/Secondary Diagnosis: Unknown at time of scheduling. Diagnosis to be determined.

Services: T1023, H2011, 90791, 90792, 90832, 90846, 90847, 90853, 90882, H0004, H0032, H0038, H2010, H2014, H2032, T1016, H0034, 90887, 90785, 90834, 90837, 90839, 90840, 90849, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99441, 99442, 99443, G0177, H0031, H2016, H2021, H2023, H2027

You Pay: $0.00

I authorize services to be provided as described. I willingly and voluntarily give my informed consent for services from this date until the end of treatment. I understand that I may revoke this authorization in writing or verbally at any time to any BHD staff. I have read and understand the Estimate of Charges listed above.

Client/Guardian Electronic Signature	Electronic Signature Date and Time
Client/Guardian Email Address	Client/Guardian Cell Phone Number
BHD Staff Member Email Address	BHD Staff Member Submitted Date