

CONSENT TO SERVICES
ADULT MENTAL HEALTH TREATMENT PROGRAM
LANE COUNTY MENTAL HEALTH

I consent to receive services in the Adult Mental Health Treatment Program. I understand that my participation in the program includes appointments with mental health professionals and consideration of treatment options that may be recommended. I consent to participate in the assessment of my need for specific treatment services that may be available. I agree to participate in the development of a treatment plan and to participate in specific treatment services and activities as arranged in that plan.

I understand that I have the right to be informed about specific services and procedures, including information about risks, benefits and alternatives to each service proposed for my treatment.

I understand that I have the right to refuse or discontinue any service or procedure. In cases where treatment has been ordered by a court you may still refuse to participate in recommended treatment however there may be legal consequences from failure to follow recommended treatment.

I understand that in the event that I fail to keep appointments and remain out of contact for 30 days services may be discontinued or interrupted.

I understand that there will be charges for services that I am provided. Clinical services that may result in a fee being charged include individual therapy, assessment and professional consultation with significant others. These **charges may be incurred via face to face sessions or via telephone** contacts. If you have insurance that we can bill this will be handled by Lane County Mental Health. If you have no insurance coverage fees will be charged directly to you based on a sliding fee scale.

I understand that the all individuals participating in treatment are expected to conduct themselves in an appropriate and respectful manner and that any aggressive, violent or threatening behavior will be basis for exclusion from service.

I understand that this consent for services is effective for the duration of my treatment in the Adult Mental Health Treatment Program unless expressly revoked.

My signature below indicates my understanding and agreement to the information above.

Signature

Date