GENERATIONS
FAMILY HEALTH CENTER

BEHAVIORAL HEALTH DEPARTMENT

INFORMED CONSENT

Patient: _____ DOB: _____

I hereby voluntarily request and authorize Generations Family Health Center's Behavioral Health Department to render the psychiatric services listed below, as clinically appropriate, to myself or my child.

Services may include:

- Individual therapy
- Family therapy
- Couples therapy
- Group therapy
- Psychiatric evaluation
- Medication evaluation and Medication management
- Care Coordination/Care Facilitation (such as referrals to community programs, insurance or other entitlement assistance, etc)

The individual treatment plan describes in specific terms the treatment for which the consent is given and is signed by patient/guardian.

I understand services may be delivered via in-person visits and/or via Telehealth. Medication Management services require minimally one in office visit every 90 days. I also understand there are many factors that determine whether an appointment is completed via in-person or via Telehealth, these factors include but are not limited to clinical need determined by the assigned provider and department/organizational expectations. I understand services via Telehealth require me to be in a safe and private area to ensure privacy and confidentiality. I understand the need to conduct myself the same via a telehealth visit as I would during an in-person office visit.

I acknowledge telehealth is optional and I may decline the service. Additionally, I acknowledge that I am responsible for verifying telehealth coverage with my insurance plan.

I understand that my provider is available to answer any questions I may want to ask. I understand that I have the right to question or refuse any treatment at any time.

While receiving services in the Behavioral Health Department, a treatment plan will be created that outlines treatment goals, discharge criteria, frequency of services as well as interventions. These will be reviewed with me on a routine basis. I understand that I have the right to request an internal review of my plan of care, treatment, or services.

6/7/2023

Adults who feel unable to make decisions about their care, or who choose to delegate decision making about their behavioral health care, treatment, and services to another individual may do so. Please complete the following information about your surrogate decision-maker.

Name: _____

Relationship: _____ Telephone #: _____

If you wish to rescind this permission in the future, you will need to complete a new consent form.

Upon your written request, information regarding professional education and experience of the treating provider will be made available.

The Generations Behavioral Health Department does not participate in Research, Experimentation, or Clinical Trials.

_____
Signature of Patient and Date

_____
Signature of Parent/Guardian and Date

_____
Signature of Surrogate Decision-Maker and Date

_____
Translator's signature (if present)