CONSENT FOR SERVICES

The undersigned client or responsible adult authorizes and consents to services by:

Didi Hirsch Mental Health Services

Based on medical necessity, these services may include assessment, substance use treatment, psychotherapy/counseling, rehabilitation services, medication, psycho-education, case management, prevention, outreach services, and other appropriate services. While these services may be delivered at different locations, all services provided will be approved and coordinated by a single staff of the agency.

RIGHTS REGARDING SERVICES

All services received are voluntary. I have the right:

1. To be informed of and participate in the selection of services.
2. To receive any of the available services without being required to receive other services.
3. To request a change in service provider (agency or staff) or withdraw this consent at any time, except to the extent Didi Hirsch already has used or disclosed my protected health information in reliance on my consent;
4. To choose whether or not to participate in research being conducted by Didi Hirsch without it affecting my treatment or the services I receive.

Information about you that we share with other entities without your permission:

1. In general, the privacy of all communications between a client and service provider is protected by law, and can only be released to others with your written permission. However there are a number of exceptions including:
    a. If the service provider suspects that a child, an elderly person, or a disabled person is being abused, s/he will be required to file a report with the appropriate state agency.
    b. If the service provider believes that a client poses a serious threat of harm to him/herself or is engaging in serious self-destructive activity, s/he may be required to contact family members or others who can help provide protection or to seek hospitalization for the client.
    c. If a client communicates a threat of serious bodily harm to another, the service provider will be required to take protective actions, which may include notifying the potential victim and the police and/or seeking appropriate hospitalizations.
    d. In order to provide the highest quality of care, your service provider may find it helpful to consult with other Didi Hirsch service providers.
2. To ensure your service provider has available to them the most complete information about you when deciding on services appropriate to your needs and for quality of care, any information you disclose to staff which is determined by them to be important to your care, will be recorded in your clinical record.
3. Information contained in a client's Health Record is available to all personnel within this agency who have a need to access the information, and will not be accessed except as allowed by Federal, State and local laws, regulations and policies allowing for accessing and sharing of confidential client Protected Health Information.

I understand that it may be necessary to include other individuals, such as family members, in my treatment. This will only be done with my knowledge and authorization. I further understand that it is my responsibility to maintain my health benefits in order to continue receiving services at Didi Hirsch, and losing my benefits may result in the termination of my treatment at Didi Hirsch.

I further understand that I am responsible for paying out-of-pocket for services received at Didi Hirsch. Refusal to make payments during a 30-day period may result in the termination of my treatment at Didi Hirsch.

I acknowledge the following:

1. I have been informed that my information will be entered into the DMH information system.
2. I have been informed about the assessment process.
3. I have received a financial screening and been informed of the screening results.

NOTE: Information about your rights and how your information is protected is described in detail in the **Notice of Privacy Practices** provided to you.

CONSENT FOR SERVICES

Text Reminder Consent

☐ I do not agree to receive text messages of my upcoming appointments on my cellphone.

☐ I agree to received text messages of my upcoming appointments on my cellphone with the following.

- I am responsible for contacting my cellular carrier regarding data usage or text fees.
- The appointment reminder texts I receive are automated and not meant for any other type of communication.
- I may withdraw this agreement at any time, without it affecting my services.

Cell Phone Number, if consent given: _____

☐ **RESIDENTIAL SERVICES - VIA AVANTA ONLY**

I, the undersigned patient or responsible person, hereby authorize Via Avanta (11643 Glenoaks Blvd., Pacoima, CA, 91331) to administer and perform any and all treatment and diagnostic procedures which may now, or during the course of the patient's care, be deemed necessary.

I understand that as a condition of receiving services from Via Avanta I agree: (1) to comply with the rules and regulations governing the program; (2) to pay any attached fees for services received; (3) to provide urine samples for urinalysis drug screening as determined by staff; (4) to participate in Child Care, Work Crews, and special projects; (5) that I will be tested within 72 hours of admission to program, (6) I will be required to have a physical examination within the first 30 days of admittance to program.

It is Via Avanta's philosophy that every client deserves the best range of services to meet their individual needs. To that end, Via is obligated to provide resources/referrals to clients who would be better served by alternate programs. It is during their first 30 days of treatment that the counseling staff evaluate the client's needs. It is Via Avanta's responsibility to provide you with referrals to alternate programs if, in our assessment, your needs fall outside the scope of our services.

I further understand that I may be discharged from the program for any of the following: (1) threat of or actual violence; (2) stealing; (3) possession of contraband, alcohol, weapons, and drug paraphernalia; (4) use of drugs/alcohol; (5) repeated refusal to comply with program rules and/or my counselor's reasonable directions.

Also, I understand that if I was referred to the program as a condition of probation, diversion, parole, or child custody determination, the supervising agency will be notified as to my discharge from the program.

CONSENT FOR SERVICES

I have reviewed and understand the above material. By signing below, I agree to these conditions and give my permission to Didi Hirsch Mental Health Services to conduct the services necessary for evaluation and treatment to (Client's Name): . I also understand that I may, at any time and for any reason, withdraw my consent for treatment.

Signature of Client	Print Name of Client	Date

Signature of Responsible Adult	Relationship to Client	Date

☐ Client is willing to accept services, but is unwilling to sign consent.
☐ A Consent of Minor form has been completed for client under the age of 18 signing without parent/guardian consent.

A copy of this consent ☐ was given ☐ was declined on _____ by _____

Staff Printed Name and Signature	Date

This consent was translated into _____ for the client or responsible adult.

*Responsible Adult = Guardian, Conservator, Parent of Minor, or other legal representative as allowable by law.