EAST CENTRAL MENTAL HEALTH CENTER
STATEMENT OF UNDERSTANDING

1. I _____ understand that information concerning the treatment of _____ will be held in confidence by East Central Mental Health Center staff unless I give specific written consent for the release of information except for requests in accordance with state and federal laws and regulations. In the event of an emergency, the center is authorized to request or release information necessary for the emergency treatment.

2. I understand that in the event of such emergency that Protected Health Information (PHI) may be disclosed to notify or assist in notifying a family member, relative, or another person responsible for my care, of my location, and general condition.

3. I understand that my PHI may be used and disclosed to carry out treatment, payment, or healthcare operations.

4. I also understand that the following types of information will be contained in my consumer files: (a) identifying demographic data (b) reason for referral or requests for treatment (c) initial assessment of need for treatment (d) any specific diagnostic evaluations necessary to formulate treatment plans (e) services provided during treatment (f) progress made during treatment (g) status of the consumer at the time of discharge from treatment.

5. I also understand that I have the right to receive information concerning the contents of my consumer file upon submitting a written request for such to my primary therapist, unless a clinical determination has been made that access would be detrimental to my health.

6. I also understand that I have the right to have information concerning the contents of my record discussed with my private attorney and/or physician, and/or licensed psychologist upon submitting a written request for such to my primary therapist.

7. I also understand that no unusual experimental treatment or utilization of special observation equipment and audio visual techniques or participation in any research will occur without full disclosure and my written consent to participate therein. I understand that I may withdraw or withhold consent at any time.

8. I also understand that I have the right to initiate a complaint or grievance and request a hearing or review of my complaints with the center's Continuous Quality Improvement Committee if I feel that I have received inappropriate or unfair treatment. I verify that I have received a statement of my rights and complaint/grievance procedures, as well as information on accessing advocacy services.

9. I also understand that I have the right to decline further services at any time during the treatment process without reprisal, except when refusal is not permitted under applicable law.

10. I acknowledge that I have received Notice of Information Practices and understand that I have the right to read the notice before signing any consent for release for my PHI.

11. I also understand that I will be charged a fee for services, according to the East Central Mental Health Center's sliding fee scale based on my annual income and the number in my family and that I am expected to pay for services as they are received. I understand that it is my responsibility to pay any co-pay/deductible required at the time of service. I further understand that I should contact my therapist if there is any change in my financial status. I certify that I have received a copy of the Fee Policy Statement, and have been given the opportunity to request assistance in securing third-party payment.

If consumer named above is a minor, or has been declared legally incompetent, I hereby give permission for treatment.

Consumer: _____

Parent or Legal Guardian: _____

Case Number: _____

Date: _____

Witness: _____

Title: _____

Date: _____

Update: _____/ _____/ _____ Witness: _____

Update: _____/ _____/ _____ Witness: _____

Update: _____/ _____/ _____ Witness: _____