SANTA CRUZ COUNTY BEHAVIORAL HEALTH SERVICES

Consent for Mental Health Services

I am requesting services for myself **or** on behalf of _____ from Santa Cruz County Behavioral Health. I understand that specialty mental health services may include (but are not limited to) individual therapy, group therapy, rehabilitation counseling, case-management/brokerage, Intensive Home Base Services (IHBS for youth), Intensive Care Coordination (ICC for youth), EPSDT services including Therapeutic Behavioral Services (for qualified youth) and medication services. These services may be provided by County and/or Contract Providers who may share information when referrals are made or to coordinate care.

I understand that I may report any dissatisfaction to Quality Improvement, 1400 Emeline Ave., Santa Cruz, CA 95060, (831) 454-4468 or to the Patient Right's Advocate at (831) 429-1913.

I have been provided written information about Advance Directives, Notice of Privacy Practices, as well as the Handbook for Medi-Cal Specialty Mental Health Services and Provider Directory (for Medi-Cal Beneficiaries only).

I understand that information and records documenting my (child's) treatment are confidential and that information about me (my child) will not be released to outside individuals or agencies (those not having a contract with Santa Cruz County to provide specialty mental health services) without my written consent, except as permitted or required by state and/or federal law or regulation. A summary of these exceptions is included in the Notice of Privacy Practices that has been provided to me.

I understand that acceptance and participation in mental health services is voluntary and I have a right to request a change of provider or service delivery staff. I understand that as a Medi-Cal beneficiary I have a right to access other Medi-Cal reimbursable services.

Maximum benefit from services will occur with regular attendance. If you cannot keep your appointment, please notify staff prior to the appointment time.

County Behavioral Health accepts Medi-Cal, Medicare, and some insurance for our services. If you do not have coverage, you will be expected to pay all or some part of the costs of treatment. The amount you pay is dependent upon your income and family size. Your share will be determined by a state formula known as "Uniform Method of Determining Ability to Pay (UMDAP). You will not be charged for school treatment services provided as a result of an Individual Educational Plan (IEP) approved by Mental Health.

I understand that there will be a separate informed consent form for psychotropic medication that may be recommended by a staff psychiatrist.

I understand that I may revoke this consent at any time and have a right to receive a copy of this consent.

Copy provided: ☐ **Initials**_____ **Copy was offered but client refused:** ☐ **Initials** _____

Client Signature_____ Date_____

Printed Name :_____

Parent/Legal Guardian Signature_____ Date_____

Individual refuses to sign but consents to mental health services verbally.

Witness_____ Date_____