SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
CONSENT FOR OUTPATIENT TREATMENT

1. Outpatient services may include assessment; diagnosis; drug and alcohol testing; crisis intervention; individual, group, or family therapy; medication; day treatment services; training in daily living and social skills; prevocational training; and/or case management services. Qualified professional staff members of the Department/Plan provide outpatient services. (You may also be financially responsible for treatment planning and consultation activities that may take place without you being present.)
2. Outpatient treatment may consist of contacts between qualified professionals and clients, focus on the presenting problem and associated feelings, possible causes of the problem and previous attempts to cope with it, and possible alternative courses of action and their consequences. You and the treatment staff will plan the frequency and type of treatment. Every effort will be made to provide you with services in the language of your choice.
3. Consent for the use of psychotropic medications, if our staff recommends them, will be on another form.
4. You are expected to benefit from treatment, but there is no guarantee that you will. Maximum benefits will occur with regular attendance, but you may feel temporarily worse while in treatment.
5. You will be expected to pay (or authorize payment of) all or some part of the costs of treatment received. The amount you pay is dependent upon your ability to pay based on your income and family size. If legal action is initiated to collect your bill, you will be responsible for paying all reasonable attorney fees and court costs in addition to any judgment rendered against you.
6. Failure to keep your appointments or to follow treatment recommendations may result in your treatment being discontinued. If you cannot keep your appointment, you are expected to notify the clinic.
7. All information and records obtained in the course of treatment, including those of a consenting minor, shall remain confidential and will not be released without your written consent except under the following conditions:
   a. As specified in the HIPAA Notice of Privacy Practices which you were given;
   b. You are a non-emancipated minor, ward of the court, or an LPS conservatee (in which case another person such as your parent or guardian, the court, or your conservator, can obtain all information about you here);
   c. Summary data about all clients is reported to the California Department of Mental Health and the California Department of Alcohol and Drug Programs, as required by them for research and tracking purposes (which includes your name and identifying information);
   d. Under certain circumstances, as set forth in Welfare and Institutions Code Section 5328, Title 42, Chapter 1, Subchapter A, Part 2 and in Federal HIPAA regulations.

   If the HIPAA confidentiality guidelines and State law differ, we will apply the one that provides your protected health information with greater protection.
8. You have the right to accept, refuse or stop treatment at any time.
9. For the duration of treatment, I authorize San Bernardino County Department of Behavioral Health to apply for and to receive payment of medical benefits from any and all health insurance plans by which I am covered, including Medicare and related public payor programs.
10. This consent informs Medi-Cal eligible individuals (including parents or guardians of Medi-Cal eligible children/adolescents) that: Acceptance and participation in the behavioral health system is voluntary and is not a prerequisite for access to other community services. Individuals retain the right to access other Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, coordinator, and/or case manager to the extent permitted by law.
11. Services are subject to termination if you possess a weapon at DBH clinics as it is a violation of Penal Code 171b. Services are also subject to termination in you threaten or assault DBH staff.

I have read the above, I agree to accept treatment and I further agree to all conditions set forth herein. I acknowledge that I have received a copy of this agreement.

Client:(print)_____ (sign) _____ Date: _____

Witness: (print)_____ (sign) _____ Date: _____

Parent/Guardian/
Conservator: (print)_____ (sign) _____ Date: _____