Cass County Health Clinic Behavioral Health
INFORMED CONSENT

PATIENT NAME:________________________ DOB:___________

I, ________________________________, give my consent for admission, treatment, evaluation, assessment and aftercare services, provided by the Cass County Health Clinic. I am aware that these services will be based on recognized and accepted methods.

I also give my consent to be treated in case of a medical emergency and authorize the CCHC to release information pertinent to my physical condition, if necessary, to medical providers. The nearest ambulance service will be called in an emergency situation and any preferences I have will be discussed with them based on my medical status.

As a convenience to you, CCHC will communicate with you, with your consent, about **NONCLINICAL** issues. Remember this is not a substitute for treatment and will only be used to address nonclinical issues such as appointment reminders, billing issues, or other administrative matters. **In the event that you need to discuss a clinical issue or believe you are having a crisis, go to the nearest hospital emergency room or call us.**

________You may call me at___________________________________
Initials

I agree to allow an appointed representative of CCHC to contact me periodically (or as specified on aftercare plan) after I am discharged from the treatment program. The purpose of contact is for support of my aftercare and to determine if entrance into active treatment is necessary. This contact will be either by telephone, personal contact or mail correspondence. I understand that this periodic contact will terminate at the end of one year (or as specified in aftercare plan), or if CCHD/CCHC is unable to contact me, or if I choose to notify them in writing that I no longer want this service.

I agree to cooperate to the best of my ability in order to achieve positive and effective treatment.

***By my signature, I am consenting to services for myself or as a legal representative of the client. *Your typed name is your electronic signature**

___________________________________ _______________
CLIENT SIGNATURE (age 12 and older) Date

___________________________________ _______________
PARENT / GUARDIAN SIGNATURE Date

___________________________________ _______________
SIGNATURE OF STAFF Date