



**Consent to Treat**

I, \_\_\_\_\_ Voluntarily consent for \_\_\_\_\_  
**Client/Parent/Legal Guardian (print full name)** **(Print client's full name if different)**

to receive services from Behavioral Health Services of Campbell County Memorial Hospital. I understand that my consent to receive services does not waive my legal rights as recognized under Wyoming and Federal Law.

\_\_\_\_\_  
**Client/Parent/Legal Guardian Signature** **Date** **Witness Signature** **Date** **Time**

**Printed Witness Name:** \_\_\_\_\_

**Emancipated Minor (Only) Consent to Treat**

I, \_\_\_\_\_, a minor of age \_\_\_\_\_, born on \_\_\_\_\_ and  
**(print full name)**

residing at \_\_\_\_\_ do represent and affirm that I am  
**(street address, city, state, and zip)**

living apart from either and both of my parents (or guardian), and that I am managing my own affairs. This representation and affirmation is made independent of my source of income. I also represent that as a result of the above, I am entitled to consent to treatment at Behavioral Health Services for diagnostic, counseling, and/or medical services as offered in connection with my clinical needs. Based on the above, I hereby give my consent and permission to Behavioral Health Services to provide me with mental health and/or substance abuse services.

\_\_\_\_\_  
**Client Signature** **Date** **Witness Signature** **Date** **Time**

**Printed Witness Name:** \_\_\_\_\_

I understand that I may be contacted by telephone or written survey, during, or after completion of, my treatment so that Behavioral Health Services may determine outcomes of, and/or my satisfaction with, the services I received. I understand that I am under no obligation to participate in these outcome or satisfaction surveys, and my agreeing or disagreeing to be contacted will in no way affect the services that I will receive at Behavioral Health Services.

I understand that for continuity of care, medication management, scheduling appointments, admission and/or discharge planning purposes, the inpatient and outpatient sections of Behavioral Health Services at CCMH, including doctors, counselors, nursing staff, case managers and support staff, may exchange information about my treatment. I understand that this information will not go outside the BHS/CCMH system, unless additional informed consent documentation is obtained.

I authorize the release of any medical/mental health/substance abuse information necessary to process my Medicaid or other insurance claims. I further authorize assignment of any payments from said insurance carriers to Behavioral Health Services. This authorization shall be valid until the insurance billing/collection process has been concluded. I understand that BHS uses a collection agency to collect any unpaid bills/debts and that disclosure of my confidential information for that purpose is allowed by Federal and Wyoming laws. I have read (or have had someone read to me), understand, and agree with the information as outlined in the "FINANCIAL INFORMATION" section of the BHS Client Information and Rights Brochure, and agree to my financial responsibilities as stated there.

I have read (or have had someone read to me), had the opportunity to ask questions and have my questions answered, and received a copy of the BHS Client Information Brochure, which includes the BHS Financial Information; Confidentiality; Client Rights; Professional Disclosure Statement; and Reporting a Problem or Safety Concern.

**Client OR Responsible Party Signature:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**Printed Witness Name:** \_\_\_\_\_

**Client Commitment to Treatment**

I agree to make a commitment to the treatment process. I understand that this means that I have agreed to be involved in all aspects of treatment, including:

- Attending sessions (or giving my therapist at least 24 hrs notice when I can't make my appointment)
- Voicing my opinions, thoughts and feelings honestly and openly, whether positive or negative
- Being actively involved during sessions
- Completing homework assignments
- Experimenting with new ways of doing things
- Taking medications only in the manner prescribed
- Implementing my Crisis Response Plan

I also understand that, to a large degree, my progress depends on the amount of energy I put into treatment. If it's not working, I'll discuss it with my therapist.

<b>Client Signature</b>	<b>Date</b>	<b>Clinician Signature</b>	<b>Date</b>	<b>Time</b>
<b>Printed Clinician Name:</b> _____				

As a result of a request for clinical services at Behavioral Health Services, and to comply with our state contract standards, we offer the following referral services. Please check the appropriate selection.

- Sexually transmitted infection testing, counseling, referral, and appropriate partner notification protocol. Health Services of Campbell County, 201 W. Lakeway Suite 414, Gillette, WY 82718
- Tuberculosis, HIV and Hepatitis B and C testing, counseling, referral and appropriate partner notification protocol. Campbell County Public Health, 2301 S. 4-J Rd, Gillette, WY 82718
- Smoking cessation class. Campbell County Memorial Hospital, 501 S. Burma Ave., Gillette, WY 82716
- I DO NOT** choose to have any of the above referrals at this time. I understand I may request any of these referrals at a later time.

Due to the nature of this request, we consider that the accomplishment of this testing and related services to be of very high importance to the client.

**Behavioral Health Services DOES NOT receive notification of follow through with referrals or the results of any testing arising from a referral. Services with Behavioral Health Services are not affected by the selection, or non-selection, of any referral.**

I acknowledge that I have been informed that the incidence of sexually transmitted diseases, tuberculosis, HIV, and hepatitis has increased among persons dependent upon alcohol and other drugs of abuse, and that I am considered to be in a high-risk population if I abuse drugs and/or alcohol.

**Client OR Responsible Party Signature:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Clinician Signature:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**Printed Clinician Name:** \_\_\_\_\_

# To Be Completed by Clients With Substance Use Related Appointments or Receiving Substance Abuse Services

## Consent for Urinalysis and Breathalyzer Testing--- For all Substance Abuse Clients

I, \_\_\_\_\_ understand that random testing to detect drug and alcohol usage is part of the Behavioral Health Services Substance Abuse Treatment Program. I consent to provide urine samples for urinalysis testing whenever requested by the treatment staff. I also consent to participate in breathalyzer tests to measure the alcohol content of my breath. I further understand that test results will be used to monitor my progress in the treatment program and determine compliance with the program rule that requires I remain drug and alcohol free while in the program.

**Test refusal or failure to provide a urine or breath sample for any reason is recorded as a positive urinalysis test.** Test refusal or positive results will result could result in (1) restarting part or all of a treatment level, being moved to a more intensive level of treatment, or discharge from the program. The results of a positive urinalysis or breathalyzer test may be disclosed for administrative processing.

I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that, in any event, this expires on \_\_\_\_\_ (no longer than one (1) year).

**I have read (or have had read to me) and fully understand this consent.**

**Client OR Responsible Party Signature:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Clinician Signature:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**Printed Clinician Name:** \_\_\_\_\_