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| **Person Served Name:** | **Avatar ID Number:** |

I consent to and authorize substance use services provided by the Fresno County Department of Behavioral Health (directly operated programs and contract agencies). These services may include counseling, crisis stabilization, crisis intervention, follow-up services, rehabilitation, medication, case management, laboratory tests, or diagnostic procedures, and other appropriate services, which may now or during the course of my care be necessary for my welfare.

I understand that DBH programs provide clinical experiences for a variety of professional trainees and interns. I understand that these individuals, who are under the direction of the supervising clinical staff, may provide treatment to me (my dependent).

I understand that information from my treatment record is confidential and will not be disclosed to others without my written consent except as permitted or required by law.  I also understand that information from my treatment record is important to my service delivery needs and that I will be asked to consent to its use and disclosure with other treatment providers with whom I have a treating provider relationship within this agency, and within the DBH system (directly-operated programs and contract agencies), or with my physical healthcare providers.

I understand that I am financially responsible for substance use services, which are not covered by third party payers. I also understand that I may apply to be charged according to a sliding scaled based upon my ability to pay, if I am unable to pay the full cost of my care and meet the qualifications for sliding fee consideration.

I have been given an opportunity to read this form and ask questions about its contents and provisions. I freely give my consent for necessary treatment and understand that I can withdraw my consent and stop receiving services at any time.

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| --- | --- | --- | --- | --- | --- | --- |
| X |  | |  | |  | |
| Printed Name and Signature of person served/parent/conservator/legal representative\* | | |  | | Date | |
| **If signed by someone other than the person served, please state your legal relationship to the person served:** | | | | | | |
|  | | | | | | |
| X |  | | |  | |  |
| Printed Name and Signature of witness/Interpreter\*\* | | | |  | | Date |
| X |  | | |  | |  |
| Printed Name and Signature of witness\*\*\* | |  | |  | | Date |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| A copy of this Consent | | [Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.] | Was given/offered | [Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.] | Was declined |  | On |  | | by |  |
|  | |  |  |  |  |  |  | Date | |  | Staff Name |
| **This section must be completed by staff if there is no signature by person served/parent/legal representative, or if signed by a minor:** | | | | | | | | | | | |
| [Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.] | Person served desires substance use services but will not sign the form. Please indicate reason: | | | | | | | |  | | |
| [Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.] | I have completed the Checklist to Determine Minor’s Ability to Consent to Treatment form for any minor between the ages of 12-17 signing above without parent/guardian consent. | | | | | | | | | | |
|  |  | | | | | | |  | |  | |
|  | Signature of Staff | | | | | | |  | | Date | |

\* A minor person served receiving services under his/her own signature must have the signed Checklist to Determine Minor’s Ability to Consent to Treatment form on file in the treatment record.

\*\* Witness/interpreter is either a person who witnessed the signing of the form (maybe staff or other person) or the person who, by signing the form, states that he/she has accurately and completely read the contents of the form to the person served or legal representative in the person’s served/legal representative’s primary language; and the person served/legal representative understood all of the terms and conditions and acknowledged agreement by signing the consent.

\*\*\* If the adult person served is unable to provide his or her full signature and does not have a legal representative, his or her own mark must be witnessed by two people.