UNICARE COMMUNITY HEALTH CENTER, INC.
CONSENT FOR TREATMENT

I consent and agree to voluntary behavioral health treatment provided by Unicare Community Health Center, Inc. (Unicare CHC), including, but not limited to, assessment, diagnosis, treatment planning, and medically necessary and recommended psychotherapy treatment. I may also be offered referral to other behavioral health and community resources, as well as crisis intervention as needed.

I understand that, while the course of my treatment is designed to be helpful, Unicare CHC can make no guarantees about the outcome of my treatment. Furthermore, I understand that the psychotherapeutic process may bring up uncomfortable feeling and reactions such as anxiety, sadness, and anger. I acknowledge that this is a normal response to working through unresolved life experiences and that these reactions will be worked on during my psychotherapy sessions.

I understand that maximum benefit usually occurs with regular attendance, and failure to keep my psychotherapy appointments may result in treatment being discontinued. I understand that if I am unable to attend my psychotherapy appointment, it is expected that I will contact Unicare CHC as soon as possible to cancel my appointment.

_____
(Initials)

I understand that all information obtained in the course of treatment, including that of a consenting minor, shall remain confidential and will not be released, except under the following circumstances:

- when I, the patient, provide written authorization to release my own protected health information
- as permitted by HIPAA for treatment, payment, and healthcare operations (outlined in the Unicare CHC Privacy Practices)
- when legal mandates require that confidentiality to be broken (including, but not limited to, instances of suspected child and/or elder abuse/neglect)
- to maintain safety in situations of danger to myself and/or others

Although it is rare, I understand that some of my protected health information *may* be released if my behavioral health condition becomes part of a legal proceeding and the release of records is court-ordered.

I also understand that my behavioral health assessment and psychotherapy progress notes are part of my integrated electronic health record with Unicare CHC, which may be accessed by other Unicare CHC providers. I also understand that my therapist may collaborate as needed with other Unicare CHC providers as needed to provide integrated healthcare.

_____
(Initials)

I understand that I have the right to accept, refuse, or stop treatment at any time and I have the right to refuse to implement any treatment recommendations. I understand that if I do not wish to continue with services, it is best to advise Unicare CHC and to work with my therapist on terminating services rather than prematurely discontinuing services, however I have no obligation to do so.

If I have an urgent (non-emergency) question/concern, I can contact the Unicare CHC 24-hour phone number (Colton—909-321-4700, San Bernardino—909-884-6700, Pomona—909-623-3600, Fontana—909-347-0700, Ontario—909-988-2555, Lincoln Heights—323-225-8038) and leave a message for my therapist. Emergency services are not provided by this clinic. If I find myself in any situation in which I am not able to keep myself and others safe, I agree to seek emergency services by calling 911 or going to the nearest emergency room.

_____ _____

Patient Signature Date

CONSENT FOR TREATMENT OF A MINOR

I/We, _____

Print Name(s) of Legal Guardian(s)

being the legal guardian(s) or legal representative(s) of the patient and on the patient's behalf legally authorize Unicare CHC to deliver behavioral health services to the patient. I also understand all items discussed in the Consent for Treatment apply to the patient that I/we represent. I/we agree to assume full financial responsibility for *all* charges not covered by insurance. If the patient has another legal guardian or legal representative, I/we certify that the other legal guardian or representative has been notified and consents to the patient receiving behavioral health treatment. Furthermore, I understand that my minor child may have the right to restrict access to their own protected health information.

_____ _____ _____

Signature of Legal Guardian/Legal Representative Relationship to Patient Date

_____ _____ _____

Signature of Legal Guardian/Legal Representative Relationship to Patient Date