CONSENT FOR TREATMENT

I am consenting to behavioral health treatment at Compass Health. I will participate in planning my treatment.

- I understand that my needs will be matched with the appropriate type of care.
- I am choosing to enter treatment.
- I understand that I can stop treatment at any time.

I understand that I can access crisis response services 24 hours a day, 7 days a week by calling 988 or 1-800-584-3578.

- If I am at Triage, E&T, or Aurora House, staff are available to help me 24/7.

PRIVACY:

I understand that information about me and my treatment may be shared among Compass Health workforce.

- Workforce members work together to provide treatment and run Compass Health.
- They will only share information when needed for each person's job.
- Workforce members may share information to help with my treatment, to collect payment for services, or to operate Compass Health.

My healthcare information is protected by several Federal and State laws and rules.

- Notices of Privacy Practices are posted, and copies are available upon request.
- The Notice of Privacy Practices explains my rights in accordance with RCW 70.02.050, 71.05.390, 71.05.630, CFR 42 Part 2, and the Health Insurance Portability and Accountability Act (HIPAA).
- Substance use disorder treatment records are specifically protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 CFR Part 2. They cannot be disclosed without my written consent unless otherwise provided for by the regulations.

ELECTRONIC HEALTH RECORD:

I authorize Compass Health to record my health care information in an electronic health record. This includes information about my substance use disorder treatment (if I receive any).

If I have substance use disorder treatment records, they may be available to Compass Health workforce members outside the substance use disorder program.

- They will only access this information as needed for purposes of treatment, payment, or to operate Compass Health.

If I am concerned about who can access my record, I can discuss this with my clinician, the program manager, or the Compass Health Quality Department.

- I have the right to request that Compass Health restrict access to my record.

I understand I can access my (or my child's) information through a client portal to the Compass Health Electronic Health Record.

- The portal does not contain the entire medical record.
- I can request access to the portal from my clinician.

Client Name/ID/DOB *(or affix label)*

TELEHEALTH:

I understand that Compass Health provides some services by telehealth. In a telehealth appointment, my health care provider would not be in the same location as me. We would communicate by phone or video.

- I may have some appointments that are audio-only (by phone or by Zoom without my camera on). However, I cannot have all my appointments that way. My clinical team and I will work together to determine how often I should be seen in person or by video.
- Compass Health will not record my telehealth visits unless I give specific permission.
- If people are close to me, they may hear something I did not want them to know. I should be in a private place, so other people cannot hear me.
- My provider will tell me if someone else from their office can hear or see me.
- Compass Health uses telehealth technology that is designed to protect my privacy.
- If I use the Internet for telehealth, I should use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see my telehealth visit.

My treatment team and I will work together to decide whether we use telehealth services. I can choose not to use telehealth at any time. If I choose not to use telehealth, my treatment team will help me understand the consequences of that choice – for example, some providers may not be available for in-person appointments.

FINANCIAL AGREEMENT:

I understand that Compass Health may bill my insurance carrier. I agree that my insurance carrier can pay Compass Health directly.

- I authorize Compass Health to disclose any and all of my medical record, including mental health or substance use disorder treatment to my insurance companies to receive payment or process a claim.
- If I receive insurance payments for services done by Compass Health, I will send them to Compass Health.
- Compass Health provides some audio-only telehealth, such as phone calls. These will be billed to insurance, or to me if not covered by insurance.
- I will inform Compass Health of any changes to my insurance or financial information.

I am responsible for fees not covered by my insurance except those noted below.

- Services provided by the Crisis Outreach Team will never be billed to me.
- Services provided by Whatcom County Triage will never be billed to me.
- If I am at the E&T:
    - If I have insurance, I may need to pay co-pays, deductibles, or co-insurance.
    - I may also need to pay for parts of the stay that are not covered by insurance.

<u>If you are receiving Substance Use Disorder Treatment services:</u>

I authorize release of all my substance use disorder treatment information to my insurance provider, or payer for my SUD services, listed here.

- Amerigroup
- Community Health Plan of Washington
- Coordinated Care
- Molina Healthcare
- United Healthcare
- North Sound Behavioral Health Administrative Service Organization
- Other
- Other

Client Name/ID/DOB *(or affix label)*

This information may be released for the purposes of payment or healthcare operations. This authorization will expire 24 months after the date of my last service. I can revoke this consent at any time by signing and dating a request, except to the extent that action has already been taken in reliance upon it. For example, if I have already received treatment based on my agreement to bill these services to my insurance provider, the services provided before I revoke my authorization may still be billed.

If you are receiving outpatient services (including IOP, WISe, PACT or Residential):

MEDICATION MONITORING:

I understand that Compass Health uses a lab service called Aegis to monitor medications.

- I will be asked to provide a urine sample at my first visit with a doctor or nurse practitioner.
- I may also be asked to provide a urine sample when my medications change, or on a regular schedule.
- This urine sample will be tested to check for the medications I take.
- It will also be tested for other substances that may interfere with my medications or wellbeing.

ATTENDANCE:

I understand that it is important to attend my appointments.

I can expect that Compass Health will:

- Provide a welcoming environment.
- Be on time for appointments.
- Create a therapeutic relationship based on trust and respect.
- Be clear about the treatment process.
- Be clear about attendance expectations.
- Help me problem solve when things get in the way of my treatment.
- Respond to my requests in a reasonable amount of time.

Compass Health expects me to:

- Be friendly and respectful to staff and other clients.
- Attend my appointments.
- Call at least one business day in advance if I need to reschedule.
- Actively participate in my treatment.

I understand that Compass Health has a policy for no-shows or cancellations. If I have 2 no-show or late cancellations within 60-days, I may be placed on an alternative scheduling plan. I may also need to use alternative scheduling if I cancel repeatedly.

Alternative scheduling means I will not have a scheduled appointment. I will be given other options for attending appointments.

Client Name/ID/DOB (or affix label)

OUT-OF-COUNTY SERVICES

☐ I will be receiving services in a different county than where I live.

I am choosing a Compass Health office in different county than where I live. I understand that because of this choice, some services may not be available to me. For example:

- A clinician will not be able to meet with me at my home, or in the county where I live.
- My clinician may be less familiar with the resources that are available in my home county.
- I need to provide my own transportation. Bus service, Medicaid transportation, or other methods of transportation may not be an option.

I have had a chance to discuss this with my assessor. I agree to receive out-of-county services. I understand the potential outcomes of this decision. If I change my mind, my clinician can help me find a health care provider in my home county.

Please complete the following sections:

Compass Health needs key information about you (or your child, if they are the one who will receive services.)
Do you have any of the following documents? If yes, please give us a copy.

Letters of Guardianship? ☐Yes ☐No

Powers of Attorney? ☐Yes ☐No

Mental Health Advance Directives* ☐Yes ☐No

Parenting Plan? ☐Yes ☐No

Are you under supervision of the Department of Corrections? ☐Yes ☐No

Are you court-ordered to mental health or substance use disorder treatment? ☐Yes ☐No

Are you on a Less Restrictive Alternative or Conditional Release court order?* ☐Yes ☐No

If you are court ordered to treatment or under DOC supervision: Is there a court order exempting you from reporting requirements? (If yes, please give us a copy.)

☐Yes ☐No

WELCOME PACKET:

I have read and understand the orientation packet material:

☐ Welcome Packet (outpatient services only – including IOP, WISe, PACT or Residential)
☐ Client Rights
☐ Clinician Disclosure Statement
☐ Mental Health Advance Directives

Client Name/ID/DOB *(or affix label)*

ALL PROGRAMS:
By signing this form, I agree that I have read the information above. I have been offered a copy of the information above. I agree to the conditions above.

Client Signature	Printed Name	Date
Parent / Guardian Signature	Printed Name	Date

Office use only:

☐ Check this box if the client or legal guardian completed and signed a hardcopy of this form and a copy was saved in the Document Management System.

☐ This consent is for family-initiated treatment and is signed by the family member of an adolescent?

☐ Materials provided in an alternate language

Client Name/ID/DOB *(or affix label)*

THIS SECTION FOR KINSHIP CAREGIVERS ONLY

It is the intent of the Washington State Legislature to assist kinship caregivers in accessing appropriate medical care to meet the needs of a child in their care by permitting such responsible adults who are providing care to a child to give informed consent to medical care.

Compass Health, in an effort to reduce barriers to mental health care for children, will accept the attestation of an adult caregiver that they are the responsible adult relative providing informed consent to mental health treatment on behalf of the child, so long as we do not have actual notice that this claim is untrue.

Compass Health will NOT accept the consent of the person named in this Declaration if consent was or is refused by any of the following:

- The appointed guardian or legal custodian of the minor.
- A person authorized by the court to consent to medical care for a child in out of home placement (i.e., DCFS);
- The minor's parents.
- The individual, if any, to whom the minor's parent has given a signed authorization to make health care decisions for the minor.
- A minor who is capable of giving their own consent (i.e., age 13 - 17).

Kinship Caregiver's Declaration of Responsibility for a Minor's Health Care

Use of this declaration is authorized by RCW 7.70.065

Minor's First Name:
Minor's Last Name:
Minor's DOB:
Caregiver's Name:
Caregiver's Address:
Caregiver's DOB:
Caregiver's Relationship to Minor (grandparent, aunt/uncle, etc.):

THIS DECLARATION IS ONLY VALID FOR SIX MONTHS FROM THE DATE SIGNED

General Notices:

1. This Declaration does not affect the rights of the minor's parents or legal guardian regarding the care, custody, and control of the minor, and does not mean that the caregiver has legal custody of the minor. It also does not affect the rights of the minor to consent to his/her own medical care where authorized by law.
2. A person who relies on this Declaration has no obligation to make further investigation or inquiry beyond what is said on the Declaration form if the provider does not have actual notice of the falsity of the statements made in the Declaration.
3. A health care provider may, but is not required to, request additional documentation of a persons claimed status as being a relative responsible for the health care of the minor patient.
4. This Declaration is ONLY valid for six months from the date above. If necessary, a caregiver may sign below to renew the declaration after its expiration.

I declare that I am 18 years of age or older and I am a relative responsible for the health care of the minor named above. I declare under penalty of perjury under the laws of the State of Washington that the above is true and correct.

Client Signature	Printed Name	Date
Parent / Guardian Signature	Printed Name	Date

Client Name/ID/DOB *(or affix label)*