Kaua`i Community Health Center
Informed Consent

Services

I, _____ give consent for the Behavioral Health Department at Ho`ola Lahui Hawai`i /
(Patient's Name)

Kauai Community Health Center to provide services to my child, family or self. these services may include assessment or evaluation; testing (psychological, psychoeducational and/or developmental); psychotheraphy in individual, group or family formats; psychoeducational training; behavioral intervention, case management, consultation; and any additional procedures agreed upon.

I agree and consent to take part in treatment with my provider. It will be reviewed regularly in order to achieving the goals in my best interest(s). I agree to play an active role in this process.

I understand that no promises have been made to me regarding the results of treatment or any procedures conducted by my provider. I also understand that therapy may cause an increase in psychological symptoms and that my provider will address these issues with me should they occur.

Patient Rights

I understand I have the following rights:

* To refuse treatment
* To be provided with names of other qualified providers
* To discontinue therapy at any time without moral, legal or financial obligation
* To ask questions and receive answers about treatment and the right to refuse unwanted therapeutic techniques.
* To be informed of any unusual procedures and to be advised of any known risks in advance
* To refuse electronic recording of any session (this will not occur without your prior written consent).
* when your provider is unavailable, every effort will be made to inform you in advance if s/he is out of town, alternative coverage will be arranged.

Limits of Confidentiality

I understand records about my treatment will be kept in written or computerized form. Information revealed about you during therapy will be kept strictly confidential and not be disclosed without prior written consent within certain limits (stated below).

There will be limited circumstances in which your provider may be required by law to reveal information obtained during therapy to the authorities without your permission and the provider will inform you of such actions. These include:

* Threatening to cause bodily harm or death to another person or yourself.
* If in a care giving situation you physically or sexually abuse a child.
* If a court of law issues a legitimate subpoena for information.
* If you have been referred for an assessment, testing, or therapy by court order and the court requires a response.
* Parents or legal guardian of minors hold privilege to information about their child's treatment.
* Another member of the treatment team who is providing care to you has a legitimate need for access to information in order to provide safe and competent care may be permitted access without your consent.
* Qualified persons may be permitted access to your record as part of professional quality assurance review proceedings.

Charges for Services

I am aware that an agent of my insurance company or third-party payer may be given information about the type(s), date(s), cost(s), and providers of any services and treatments I receive. I understand that I will be charged for things not covered by insurance, such as co-payments. As a result, you are encouraged to contact your insurance carrier to determine the specifics about your coverage. If you do not have health insurance, you will be charged on a sliding fee scale that is based on family income and size.

I have read the above and understand the nature of services provided, my rights, limits to confidentiality, and charges for services. I have also received a copy of the informed consent.

Patient Signature		Date:	

I have discussed these issues above with the patient. my observations of this patient's behavior and responses give me no reason, in my professional judgment to suggest that this person is not fully competent to give me no reason, in my professional judgment to suggest that this person is not fully competent to give informed and willing consent.

Provider Signature		Date:	

Print Form