INFORMED CONSENT FOR TREATMENT

GENERAL INFORMATION

I, _____ , voluntarily give my permission and consent to The Affiliated Sante Group (ASG) for providing behavioral health services including evaluation, treatment and/or services provided by ASG. I have been informed and understand that the services rendered by ASG may include an intake, diagnostic process, evaluation of treatment and/or rehabilitation needs and any additional evaluations, therapies, and/or medication that may be recommended or provided by the ASG and its programs. I understand that the information gathered through the above interventions will be used to help me develop a crisis plan when necessary. I have had these services explained to me and have had the opportunity to ask questions. Any questions I asked were answered fully to my satisfaction.

I understand and acknowledge the results of evaluations will be made available to me as appropriate according to law. I understand all evaluation, treatment, and services are voluntary and I may request, refuse, and/or terminate any or all of them at any time which request ASG will honor. I understand the consequences, if any, will be explained to me if I refuse or terminate evaluation, treatment, or services.

CONFIDENTIALITY

I understand and acknowledge that strict confidentiality of my information is practiced and ensured by ASG with the following exceptions:

1. If I have signed a consent form to release designated information to named parties.
2. If there is a court order signed by a judge directing the release of designated information to named parties.
3. If ASG finds that there is a perceived threat of injury to myself or others, ASG is legally bound to disclose certain information to designated parties.
4. If ASG believes that there is a suspicion of abuse involving children or other vulnerable individuals (e.g.., intellectually disabled or elderly adults) ASG is legally bound to disclose certain information to designated parties.
5. If ASG is required to defend against a claim or investigation it may use certain designated information in its defense.
6. If ASG is part of a legitimate audit certain information may be disclosed.
7. If ASG is required to disclose certain information in order to obtain payment from a third party payer.

I understand and acknowledge that demographic and utilization information regarding my treatment and/or services may be reported in statistical form to the State of Maryland and/or the contracted managed care organization. This information will be kept confidential and may not be released to any other agency or person without my consent except as identified previously. I understand that information obtained by law enforcement during my involvement with ASG may not be covered by ASG's confidentiality policy. All substance abuse information will be confidential according to 42 CFR Part 2.

I understand that although email and text message correspondence may not be considered as a preferred form of communication between consumer and staff, there may be times when these forms of communication may be useful and necessary. I understand any information relayed in email or text message will be limited and will not be used to provide any form of treatment. You are advised that ASG cannot guarantee complete privacy with regards to text messages and emails that you send. I also understand that ASG will apply reasonable safeguards to protect confidentiality with regards to these forms of communication.

FEES

I acknowledge that any fees for evaluations, treatment, and/or services provided by ASG are charged to the contracted managed care organization or to my insurance plan. I understand services provided by agencies, programs, or companies working with ASG are billed and paid for in accordance with that agency's programs, or company's procedures. I also understand ASG is not responsible for explaining the provisions contained in another agency's programs or company's billing structure or procedures.

NOTIFICATIONS

I acknowledge I have been provided a copy of ASG's Human Rights Notification, HIPAA Privacy Practices, Grievance Procedures and general orientation information. I acknowledge this information was explained satisfactorily to me and I was given the opportunity to ask questions and am satisfied with the responses given to me.

STATEMENT OF UNDERSTANDING

By my signature, I indicate that I have reviewed and understand the above information. I acknowledge that my rights as a consumer have been satisfactorily explained to me and I had the opportunity to ask questions and am satisfied with the responses given to me. I understand that I may withdrawal this consent at any time. I voluntarily give my informed consent for evaluation, treatment, and/or services.

Consumer or Consumer Representation Signature	Date
Print Name of Consumer Representative	Relationship of Representative to Consumer
Staff Signature	Date

HUMAN RIGHTS NOTIFICATION

Individuals receiving services from any program are entitled to the following human rights.

Non-Discrimination: You are entitled to receive treatment regardless of your race, color, religion, creed, ancestry, national origin, physical or mental disability, veteran status, gender, gender identity, gender expression, age, social-economic status, intellectual ability, sexual orientation, political opinion, personal appearance, physical characteristics, marital or familial status or any other characteristic protected by law. You will be treated with courtesy, respect, and full recognition of your individuality. You have the right to dignity, privacy, and humane care. You have the right to live as normally as possible while receiving care and treatment.

General Information: You are entitled to be informed about all rules of the program and services and the nature of the services provided. Before your admission to the program, you will be informed of admission, attendance, and discharge policies. You have a right to know why you are being discharged and the plan for your mental health and physical health requirements after you are discharged. You have a right to be informed of all the programs and services of the company. You have the right to access a private physician of your choice at your own expense.

Fees: In clear language that you can understand and before you are admitted to the program, you are entitled to know how much your treatment costs, who will pay for it, any limit to the amount they will pay, and any amount for which you are responsible for payment. You have a right to be free from exploitation for financial gain. This includes misuse of any funds for your use or care.

Treatment Services: All services will be provided consistent with relevant federal, state, and local laws and regulations. Your treatment will be provided in the least restrictive environment that is available and appropriate for your needs. You will be informed which staff member(s) are responsible for your care. You will be asked to participate in the development of your treatment plan and your treatment will be provided consistent with the plan you helped develop. You may ask for a review of your treatment plan at any time. You have the right to be informed of alternative types of treatment. You will be informed about any changes (and why) in your treatment. You have a right to have your care explained to you and to be informed what we will do if you refuse any treatment. You have the right to refuse treatment, but if treatment is ordered by a court, we will be obligated to inform the court of your decision.

Medication: You may refuse medication as part of your treatment. If you choose to take medication, you will be informed of the reasons for it, what it is intended to do, of any common side effects, and of any risks associated with the medication.

Research: You have the right to refuse to participate in any research trial. You will be informed if you will be participating in any medication (or other treatment) trial prior to being placed in a research trial. If you do choose to participate in such a trial, you will be given all relevant information required by law so that you can make an informed decision about your participation.

Media use: You have a right to know if any audio or visual recording devices, television, movies, or photographs will be used in your treatment. You have the right to refuse the use of any such devices and to understand what outcomes will happen, if any, if you refuse to have them used.

Restraints: You have the right to be free of all chemical and physical restraints. The Company will not use restraint, restrictive interventions, or seclusion on any of the participants enrolled in any program. All staff will address conflict situations with positive interventions such as by separating individuals and talking out problems.

HUMAN RIGHTS NOTIFICATION

Confidentiality: All of the information recorded in your record, in accordance with medical record policy is confidential *except for legal or regulatory exceptions including the following:*

- You have signed and completed an *Authorization to Release Private Health Information* form that is valid for no more than one year from the date it is signed or until its intended purposes are completed. You may cancel in writing or verbally your authorization at any time.
- There is a court order signed by a duly appointed or elected judge.
- There is a perceived threat of injury to yourself or others or there is the likelihood that you will commit a felony or violent misdemeanor.
- There is a suspicion of abuse involving children or other vulnerable individuals.
- Representatives of a funding source for your treatment or services require that your records be made available to them.
- You are an inmate in the Department of Correction and are determined to need treatment for mental illness, developmental disabilities, or substance abuse.
- You are receiving emergency medical treatment (only the information necessary to meet the emergency will be released)

Record review: You (or your legally responsible person) have a right to review your record consistent with company procedures and legal requirements. You can contact the Program Director to request a copy of your record.

Freedom from abuse: You have the right to be free from mental or physical abuse, harassment, physical punishment, or humiliating, threatening, or exploiting actions. You have the right to have any allegations of abuse reported to local law enforcement agencies.

Legal: You have the right to representation by a lawyer in matters relating to your care. You may consult with a lawyer and have your lawyer interview staff members who work with or previously worked with you under reasonable circumstances. You may have access to your medical records in accordance with company procedures and legal regulations. You have a right to have your lawyer provide information before a hearing or other judicial proceeding.

Advance Instruction for Mental Health Treatment: Maryland individuals have the fundamental right to control the decisions about their mental health care. The State of Maryland has established an additional, nonexclusive way for an individual to exercise the right to consent to or to refuse mental health treatment when the person does not have sufficient understanding or ability to make or communicate mental health treatment decisions. You have the right to complete a mental health advanced directive to make your choices known. If you are interested, please contact the Maryland Disability Law Center at 1-800-233-7201 or TTY 410-727-6387

Grievances: You have a right to present a grievance you have and to understand how we handle your complaint. Maryland consumers also have the right to contact the Office of Health Care Quality with Maryland's Department of Health, the statewide agency designated under federal and state law to protect and advocate for the rights of persons with disabilities. You **will not be penalized** for filing a grievance or complaint about your care or treatment.

Input into Services: You have the right to provide input regarding the service quality and care you received. There are several ways to provide such input. You may:

- Complete the Consumer Satisfaction Survey
- Call the CEO/President of the Company to provide input
- Mail a statement to the Director of Corporate Compliance at: 810 Tyvola Road Suite 126 Charlotte, NC 28217.

Standards of Professional Conduct: You have the right to be cared for with the upmost respect and with a high standard of quality care. The Company adheres to the Standards of Professional Conduct outlined by the American Counseling Association's Code of Ethics. Each counselor also adheres to his/her licensing board's Ethical Standards of Professional Conduct.

GRIEVANCE PROCEDURES

The following is an outline of the Grievance Procedures for consumers who receive services from The Company.

Consumers will be given information on the grievance policy at the time of admission and asked to sign a form acknowledging receipt of the policy. Informal complaints/grievances are reports intended to or able to resolve the concerns at the earliest stages possible. Formal complaints are when the concerns are more egregious in nature (e.g. violation of rights, discrimination, harassment, etc.) and an informal complaint is not appropriate.

All formal consumer complaints/grievances will be responded to in the following manner:

1. Consumers may initiate a complaint or grievance by informing a counselor, the Clinical Coordinator/Supervisor, or any staff member of their concern.
2. Consumers will then be asked to submit the grievance initially to the direct care staff in writing or verbally. The direct care staff will inform the Clinical Coordinator/Supervisor of such concern.
3. If direct care staff is unable to resolve the grievance to the consumer's satisfaction, then the consumer will be asked to meet with the Clinical Coordinator/Supervisor to review the grievance and determine a resolution or plan of action within 5 working days of the initial complaint/grievance. (Consumers with literacy challenges can contact the Clinical Coordinator/Supervisor by telephone, and the Clinical Coordinator/Supervisor will document such call).
4. If the consumer is still not satisfied with the resolution or plan of action, the consumer will be asked to meet with the Program Director. Once the consumer has met with the Program Director, the Program Director will resolve the issue or take the issue to the Director of Corporate Compliance for a final decision. The Program Director will provide a written response to the consumer within 5 days of the meeting that includes:
   a. A summary of the complaint/grievance as presented by consumer
   b. The decision of the Program Director with respect to the grievance
   c. Explanation that the consumer may ask the Program Director to present the complaint/grievance to the Director of Corporate Compliance for review

Every consumer has the additional right of addressing a grievance with the Maryland Disability Law Center at 1-800-233-7201 or TTY 410-727-6387 or the appropriate LBHA. Contact information will be made available upon request.

The Program Director will retain all consumer grievance files and will review all complaints with the Director of Corporate Compliance, and if appropriate, the Operations Committee.

All consumers must be informed that, at any time, they may seek outside assistance with their complaint/grievance, such as from the referral source or from other agencies.

The Company with comply with the LBHA and/or Department of Health policy regarding any complaint lodged against the Company to the LBHA or DHS.

Consumers will be free from any form of retaliation or barriers to services as a result of any action they take to regarding the filing of a grievance.

This is notice that the consumer may submit any concerns and/or grievances in writing to: The Affiliated Santé Group, 12200 Tech Road, Suite 330, Silver Spring, MD 20904, ATTN: Director of Corporate Compliance.

SANTÉ

Authorization for the Release/Exchange of Protected Health Information

Name of agency/person that information can be released to or exchanged with. ("Receiving Party")	Name of agency/person that information can be released from or exchanged with. ("Releasing/Exchanging Party")

I, _____, hereby authorize that the above-name Releasing/Exchanging Party shall release/exchange the following health information to the above-named Receiving Party:

☐ Psychiatric Evaluation	☐ Information obtained from other agencies	☐ Discharge/Transition Pan
☐ Lab results	☐ Results and recommendations of assessment	☐ Medication information
☐ Participation and attendance	☐ Medical Information	☐ Treatment Plan
☐ Entire Medical Record	☐ Other: _____	

For the specific purpose of:

☐ Aiding in and coordinating services	☐ Legal purposes
☐ Insurance/Managed Care purposes	☐ Other: _____

This Authorization is valid until one year after the signature date, for the period of time needed to fulfill its purpose, or until the date expressed by the client (please indicate date if less than one year) _____.

The exception to this time period is in the case of disclosures for financial transactions, or as otherwise authorized by law, where the Authorization is valid indefinitely. I also understand that I have the right to revoke this Authorization at any time and that in order to do so I must sign the *Revocation Section* on this form. I further understand that any actions taken pursuant to this Authorization prior to the revocation date and time is legal and binding. I understand information may be released verbally, in writing, by mail, via secured electronic means or secured facsimile.

In accordance with 42CFR Part 2, I understand that my information should not be re-disclosed by the requester of the information without my further written authorization and that this information may be protected by the Federal Substance Abuse Confidentiality Regulations. In any event the recipient should not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to chronic illnesses, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information unless I specifically exclude such information from disclosure.

I also understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), that service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed Authorization.

_____ Client Signature or legally appointed representative

_____ Client Date of Birth

_____ Date

_____ Witness Signature

_____ Date

Revocation Section

I do hereby request that this Authorization to disclose health information of _____ *(Client's Name)* on _____ *(Date of Original Signature)* be revoked, effective _____ *(Today's Date)* at _____ *(Time)*.

I understand that any action taken on this Authorization prior to this revocation date and time is legal ad binding.

_____ *Client Signature* _____ *Date* _____ *Time*

_____ *Witness Signature* _____ *Date* _____ *Time*

Verbal Revocation Section

I do hereby attest to the verbal request for revocation of this Authorization by _____ *(Client's Name)* on _____ *(Date)* at _____ *(Time)*.

The client has been informed that any action taken on this Authorization prior to the revocation date is legal and binding.

_____ *Staff Signature* _____ *Date & Time* _____ *Witness Signature* _____ *Date & Time*