



House of New Hope

8135 Mt. Vernon Rd.
St. Louisville, Ohio 43071
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Consent for Mental Health Treatment

I, (full name/relationship) _____ hereby
give consent to House of New Hope to provide mental health services to (client full name)
_____, (date of birth) _____.

Further, I understand that each service that I receive has potential benefits and risk associated with it. Possible benefits and risks are outlined below and have been explained to me. My signature, dated today, indicates that I wish to receive services as described.

Diagnostic Assessment

I understand that Diagnostic Assessment Services, which may include a review of referral materials, face-to-face interviews with me and significant others, and use of formal assessment protocols, are designed to assist in the development of a clearer picture of my social, emotional, medical, and behavioral needs. A potential benefit is that gathered information may be utilized in planning for one or more of the following life domains: mental health, social and recreational, educational and/or vocational, legal, cultural/spiritual, safety and crisis, and habilitation. The possible risks associated with refusing or stopping this service is that there may be insufficient information available for sound planning on my behalf. This, in turn, may limit my access to services and interventions aimed at facilitating my development of skills needed for a more adaptive way of living. I understand that I have the right to withdraw my consent for these services at any time.

Consent to accept Diagnostic Assessment Services

Refusal to accept Diagnostic Assessment Services

Counseling and Psychotherapy

I understand that Counseling and Psychotherapy Services are designed to help me and/or my family to address specific problems and goals identified in the Individualized Service Plan. This service is primarily a talking and listening service that affords me the opportunity to improve aspects of my mental health, emotional functioning, and interpersonal relationships as primary benefits. The possible risks associated with refusing or stopping this service may include either a continuation or worsening of the symptoms and problems that led to my need for counseling and psychotherapy. This, in turn, may result in the need for more intensive and restrictive intervention and services. I understand that I have the right to withdraw my consent for this service at any time.

Consent to accept Counseling and Psychotherapy Services

Refusal to accept Counseling and Psychotherapy Services

Crisis Intervention Service

I understand that Crisis Intervention Services are designed to provide responsive assessment, immediate stabilization, and the determination of a level of care in the least restrictive environment when an emergency arises. This service is primarily concerned with the safe de-escalation of an individual or situation, provide hospital pre-screening and mental status evaluation, determine appropriate treatment services, and coordinate the follow-through of those services and referral linkages. The possible risks associated with refusing or stopping this service may include an inability to: deescalate or stabilize the individual or situation, link the individual to the appropriate level of care and services, develop a safety or crisis plan, or resolve the emergent situation. This, in turn, may result in the need for more intensive and restrictive intervention and services. I understand that I have the right to withdraw my consent for this service at any time.

Consent to accept Counseling and Psychotherapy Services

Refusal to accept Counseling and Psychotherapy Services

Consent for Mental Health Treatment Services

_____ Person Served Date _____ Witness Date

_____ Parent/ LegalGuardian Date

Withdrawal of Consent

I withdraw consent for (name of mental health service) _____.

Further, understand the implications and potential consequences of refusing or withdrawing consent for treatment.

Further, I have been offered an opportunity to help develop alternative approaches to gaining access to needed services.

_____ Person Served Date _____ Witness Date

_____ Parent/Guardian Date