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# Comprehensive Substance Use and Mental Health Assessment Consent Form

*You have been referred for a comprehensive substance use and mental health level of care assessment. Please review the following information carefully.*

Participation in the assessment is voluntary and optional. You may decide to discontinue the assessment at any time by notifying the clinician.

The assessment consists of completing intake paperwork and questionnaires, attending 2 to 3 one-hour sessions with a clinician, and clinician's review of collateral information from other providers who you may be working with. Collateral information might include documents from DCF; DOC/Probation and Parole; mental health and substance use diagnoses, assessments or records; urine drug screen results; medical records and/or medications from a primary care provider, psychiatrist or other provider; or other information.

Assessments are typically conducted via telehealth. Clinician provides a secure telehealth platform, however, it is your responsibility to ensure privacy on your end by logging on to the telehealth session from a private space. Due to telehealth rules, clinician will ask your location and whether anyone else is present at the beginning of each session.

Participating in the assessment may cause some emotional distress or discomfort if difficult topics are addressed. If you do not feel comfortable talking about a specific subject or answering a specific question, please let the clinician know.

Assessments are billed at $150 per session. If you have health insurance and your clinician is in network, your health insurance benefits may be used towards the assessment. You are responsible for knowing your health insurance plan and coverage information. Many health insurance plans have additional out of pocket costs. You are responsible for any out of pocket costs in the event that insurance does not cover the service or does not cover the full amount. Your signature on this form authorizes a credit/debit card to be kept on file and to be charged any outstanding amount.

Any unpaid balances will be sent to collections after 60 days.

All intake paperwork needs to be completed prior to scheduling the assessment. This may include: demographic information, screening tools/questionnaires, insurance information and credit card information. Assessments will not be scheduled without providing copies of

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insurance cards and subscriber information for ALL insurance plans and/or an out of pocket payment agreement and credit/debit card information.

All information obtained in the assessment is confidential and protected under HIPAA and/or 42 CFR. Information cannot be disclosed except in the following situations:

1. The client signs a release authorizing the sharing of information
2. A court, judge or subpoena mandate the release of information
3. There is risk of harm to the client, another person, or risk of significant property damage
4. Information regarding harm or risk of harm to a child, elderly, disabled or vulnerable individual is shared which clinician as a mandated reporter is required to report to DCF Family Services or Adult Protective Services

At the completion of the assessment, a recommendation for level of care will be determined, based on the information obtained during the assessment. Recommendations could include a range of services from "no treatment indicated" to hospitalization, inpatient treatment, or residential treatment. Referrals to other community providers such as outpatient therapy, recovery centers, medication assisted therapy or intensive outpatient programs are common.

The recommendation will be provided in a 1-2 page document which includes summary of the assessment and the recommendations. This document will be provided to you as well as to the referral source, provided you have signed a release of information for the referral source.

*Your signature below indicates that you have read and understand the information above; you are not agreeing to participate in the assessment and this is not a guarantee that services will be provided.*

_____

Name Signature Date