CLATSOP BEHAVIORAL HEALTHCARE

65 North Highway 101, Suite 204
Warrenton, Oregon 97146
Phone (503) 325-5722 Fax (503) 861-2043

Consent to Treatment

Client Name:_____ DOB:_____

I have received information on the Declaration for Mental Health Treatment. This document allows me to make decisions about my care if I am unable to make them because of a mental health emergency. If I wish to complete a declaration, I will speak with my clinician.

__ Yes __No Consent for photo to be taken for my file; used for identification purposes only.

The following documents have been given to me:

__ Yes __No CBH Client Orientation Packet (Grievance Policy, Consumer Rights, etc.)
__ Yes __No Treatment Attendance Policy
__ Yes __No Notice of Privacy Practices
__ Yes __No Voter's Registration Card
__ Yes __No Declaration for Mental Health Treatment
__ Yes __No Investigation and Resolution of Complaints Policy and Procedures

I understand fully and I now want to freely give my informed consent for myself and/or minor child or legal dependent, to be in treatment at Clatsop Behavioral Healthcare.

I hereby consent to participate in the services provided at Clatsop Behavioral Healthcare.

I understand that Clatsop Behavioral Healthcare is responsible to continue treatment unless no appropriate care is available or unless I fail to meet my responsibilities as described in the Treatment Attendance Policy.

I consent at this time to enrollment at Clatsop Behavioral Healthcare.

_____ _____
Client Signature Date

_____ _____
Parent or Legal Guardian Signature (If client is under 18 years old) Date