Pillars Community Health
Healing. Caring. Educating.

Informed Consent to Mental Health Services

Client Name: _____ Date of Birth: _____ Client ID: _____

I have been given and understand the materials listed below which explain Pillars Community Health procedures:
Orientation Handbook, Fee Policies and Agreement, Insurance and Coverage Explanation, Client Rights and Responsibilities, HIPAA Notice of Privacy Practice

Mental health services may include: Mental Health Assessment, Treatment Plan, Crisis Intervention, Individual/Family or Group Therapy, Case Management, Community Support, Psychological Evaluation, Psychiatric Evaluation/Psychotropic Medication Monitoring.

Benefits of Treatment may include but are not limited to: Improvement in your personal/interpersonal relationships; increased coping skills to help reduce stress; increased satisfaction with your quality of life; increased insight and personal awareness; increased skills for dealing with specific problems; determining your strengths and goals for treatment, prioritizing these goals, and deciding how you will achieve them.

Risks of Treatment may include but are not limited to: Significant others may notice changes you make that may affect your relationships; you may experience uncomfortable feelings such as anxiety, anger, guilt, sadness, loneliness or helplessness or other emotions that might be painful, and/or recall unpleasant memories. Staff will support you if these things arise.

We also want you to be aware that other treatment options are available to you, such as working with another provider, pursuing specific treatment modalities that Pillars Community Health may not offer (biofeedback, residential services, etc.). We will assist you with referrals if you would like to pursue alternative treatment options.

If you are receiving telehealth services, please let your provider know if you will be out of state during your appointment time so they can reschedule during a time when you will be in town. It is our policy that we do not provide telehealth services if you are not in the state of Illinois.

Electronic Communication: Email, text and other forms of electronic communication are **NOT** confidential and we will not share any of your protected health information (PHI) by these means. If you wish to communicate with us using any of these means for scheduling of appointments or other purposes that do not include PHI, please indicate your consent to do so by signing below. **OR--**
☐ **I DO NOT CONSENT TO BEING CONTACTED BY EMAIL, TEXT, OR OTHER FORMS OF ELECTRONIC COMMUNICATION.**

Having been so informed, I agree to treatment at Pillars Community Health.

Signature of Client (12 yrs and older) **Date**

Signature of Parent or Guardian **Date**

Signature of Staff Member **Date**

Note: If Therapist has any concerns regarding client's ability to give informed consent, explain in this area.