WILLOW OAK COMMUNITY BEHAVIORAL HEALTH CENTER

CONSENT FOR TREATMENT

Willow Oak Community Behavioral Health Center (WOCBHC) is committed to providing affordable but effective treatment services. Acceptance of individual responsibility for recovery includes being able to voluntary participate in treatment.

TREATMENT

I authorize and consent to Willow Oak staff providing outpatient behavioral health treatment as determined to be medically necessary in their professional judgment. I have been informed of the nature and purpose of the treatment and the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period.

MESSAGES OR APPOINTMENT REMINDERS

Messages will be of a non-sensitive nature, such as, appointment reminders.
May we leave a message at your home using the Willow Oak/treatment provider name?
❏ Yes ❏ No
May we leave a message at your work using the Willow Oak/treatment provider name?
❏ Yes ❏ No

HEALTH INFORMATION DISCLOSURES

I understand that as part of treatment, payment or Willow Oak operations, it may become necessary to disclose health information to another entity, e.g. referrals to other health care providers. I consent to such disclosure for these uses as permitted by law. I fully understand the information of this consent.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with the Willow Oak Notice of Privacy Practices that provides a description of Protected Health Information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this statement. I understand that Willow Oak reserves the right to change its Notice of Privacy Practices that will be effective for health information the agency already has about me, as well as any they receive in the future. Willow Oak will post a current copy of the Notice. I understand that I may obtain a copy of the current Notice in effect upon request. I have read all of the above and understand/ agree to all provisions therein regarding responsibility for payment, permission for treatment and Notice of Privacy Practices.

My signature below signifies that I have reviewed the consent for treatment associated with Willow Oak. I have had an opportunity to ask questions and receive answers. My signature indicates my willingness to proceed with treatment.

____ ________________

Individual Signature **Date**

Printed Name: _____________________________________

____ ________________

Willow Oak Representative Signature **Date**