SIGNATURE PAGE San Luis Obispo Behavioral Health Department	☐ DAS 2180 Johnson Ave, San Luis Obispo, CA 93401 Phone: (805) 781-4275 FAX(805) 781-1227	☐ MH 2178 Johnson Ave, San Luis Obispo, CA 93401 Phone: (800) 838-1381 FAX (805) 781-1177

TREATMENT AUTHORIZATION

TREATMENT AUTHORIZATION: I, the undersigned, am requesting mental health services and/or drug and alcohol services and give my consent to the staff of the San Luis Obispo County Mental Health Services and/or Drug and Alcohol Services to administer such treatment as is considered therapeutically necessary and/or desirable. All treatment procedures, including observed urinalysis for drugs of abuse, patching, and breathalyzer, are to be discussed with me and I am free to decline or withdraw from treatment at any time. I expect to receive quality, professional care and understand that there is no guarantee that desired results will be obtained. I understand that San Luis Obispo County Mental Health and/or Drug and Alcohol Services will maintain a medical record of my contacts for services as required by law. This is a shared electronic health record between Mental Health and Drug and Alcohol Services. The confidentiality of these records is protected by law and no information which might identify me will be released without my specific written consent. Exceptions to this confidentiality are: Medical emergencies, the requirements for billing, a judge's order to release information to a court, unreported abuses of a child, dependent adult or elder, or in the event that I am of danger to myself or others.

Client Signature _____ Date_____

Parent, Guardian or LPS Conservator Signature_____ Date_____

Legal Consent	
Responsible Person	
Address, City, State, Zip	Phone

INSURANCE AUTHORIZATION

I hereby authorize San Luis Obispo County Mental Health Services and/or Drug and Alcohol Services to receive payment of medical benefits for any and all health insurance plans for which I am covered, including Medi-Cal, MEDICARE and private health insurance. I further authorize the San Luis Obispo County Mental Health Services and/or Drug and Alcohol Services to disclose portions of any record generated or maintained by Mental Health Services and/or Drug and Alcohol Services regarding me, including all health information pertaining to my medical history, mental or physical condition and treatment received, and information recorded in the diagnosis and treatment of my mental health and/or drug and alcohol related conditions, to any person or corporation which is or may be liable for, all or any portion of Mental Health Services and/or Drug and Alcohol's charges, including, but not limited to insurance companies, health care service plan, or workers' compensation carriers and government reimbursement entities. The purpose of the disclosure authorized by this form is for Mental Health Services and/or Drug and Alcohol Services to determine liability for payment and to obtain reimbursement for its own or ancillary services. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year (1 year) from the date the case closes. I understand that I might be denied services if the County can, under federal or state law, condition treatment on the provision of an authorization, such as to obtain information in connection with a health plan's eligibility or enrollment determinations. I will not be denied services if I refuse to consent to a disclosure for other purposes. I understand that I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of under this authorization. I have been provided a copy of this form.

Client/Responsible Party Signature : _____ Date_____

RECEIPT OF CLIENT HANDBOOK

I have received a copy of the following: (Initial each line as it applies to each client)

1.____ Privacy Practices - I hereby acknowledge that I received a copy of County of San Luis Obispo Health Agency Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the lobby area, and that I will be offered a copy of any amended Notice of Privacy Practices at my appointment.
2.____ Client's Rights and Grievance Procedures. This is also posted in the lobby area.
3.____ HIV/AIDS, Hepatitis C, and TB Information sheet. Phone numbers included for testing and referrals.
4.____ Information on Drug Testing including: Drug testing guidelines, medications/substances that may test positive on your drug screen, and over-the-counter medications okay to take while drug testing.
5.____ Follow-Up Consent - I agree to comply with the San Luis Obispo County follow-up procedure. I understand that this entails responding to a questionnaire regarding my status at 90 and 180 days after discharge from the program. I further understand that this information will be strictly confidential, and that I may be offered a follow-up appointment based on the information I give.
6.____ Advance Directive
7.____ List of Community Service Providers has been given to me.
8.____ Beneficiary Medi-Cal Handbook
9.____ *I have read, understand, consent, acknowledge and agree to abide by the terms and conditions in the Client Handbook.*

Client Signature:_____ Date_____

Parent, Guardian or LPS Conservator Signature_____ Date_____

Signature of Staff Person Witnessing:_____ Date_____

If not signed by the client, please indicate relationship:

☐Parent or guardian of minor client ☐Guardian or conservator of an incompetent client ☐Beneficiary or personal representative of deceased client

CLIENT NAME	CLIENT NUMBER