San Luis Obispo County Behavioral Health Department

BEHAVIORAL HEALTH SERVICES

Date:

MENTAL HEALTH BEHAVIORAL INTERVENTION AGREEMENT

Name of individual entering into agreement:

Last Name: First Name:

The purpose of this agreement is to support the clear communication of expectations between you and your treatment team. Establishing shared expectations and guidelines help create safety and boundaries that can aid your progress in treatment and help you reach identified therapeutic goals.

Clients receiving outpatient services in our clinics are required to behave in an appropriate and respectful manner and to protect the confidentiality of fellow clients.

Situation that led to this discussion:

I understand I am responsible to:

- ☐ Keep my appointments, which will help me benefit the most from my treatment. If I fail to keep appointments, SLOBHD may stop my services.
- ☐ Act in a respectful manner. If I am violent or threatening to staff or other clients, SLOBHD may change or stop my services. If I commit a crime at the site, SLOBHD may press charges.
- ☐ Protect the confidentiality of other clients. If I violate other clients' confidentiality, SLOBHD may change or stop my services.
- ☐ Participate in treatment by talking with SLOBHD staff about my choices.

My signature signifies my agreement to comply with the expectations described above and my understanding that if I do not follow these expectations I may be discharged from services.

Signatures

Signature	Signature Line Heading	Printed Name	Date
	☐ Client		
	☐ Staff		