EXCELSIOR
WELLNESS CENTER

INFORMED CONSENT

1. I understand that Excelsior is a private, not-for-profit health care and educational organization, incorporated and licensed in the State of Washington. Excelsior offers healthcare and behavior health programs with varied lengths of enrollment episodes. I understand that my participation in services with Excelsior will be based on my individual goals/needs and will not be compared to others.

2. I understand that I am responsible for all costs at the time of the service unless I am receiving services through an agency (i.e. MCO, DSHS or the BHO) that has contracted to pay for necessary treatment for an approved length of time. Excelsior will submit claims to valid insurance carriers. I am responsible for claims denied by my insurance company for any reason. Parents/Guardians of children under the age of 18 agree to be responsible for any costs related to service. A current fee schedule is updated annually and will be offered to me at my request. If I ask Excelsior to bill an insurance carrier, I authorize Excelsior Youth Center to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of treatment services; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

3. I understand that my behavioral healthcare provider will hold all information that I share confidential. I understand my Personal Health Information (PHI) may only be released with my written permission, except as required by law. Behavioral healthcare providers are required by law to report to law enforcement and/or the Department of Social and Health Services when we learn of a) abuse or neglect of a minor or vulnerable adult; and b) intent and plans of individual to harm him/ herself. Your behavioral healthcare provider is also authorized by state law to notify any individual in an effort to prevent imminent danger to the health and safety of them.

4. I understand that I am expected to attend all scheduled appointments, groups and meetings. I am expected to give at least a 24 hour notice if an individual or family session needs to be cancelled or rescheduled. I am expected to give at least a 6 hour notice if I am unable to attend a group counseling session.

5. I understand that although counseling will seek to improve my life, the process may stir unpleasant thoughts or feelings, such as anger, fear, anxiety, stress, depression. Counseling may involve risk of other discomforts. I am encouraged to discuss the difficult aspects of counseling with my behavioral healthcare provider. There can be no guarantee of the benefits of counseling.

6. I agree that I will neither hold nor attempt to hold Excelsior, and/or any staff personnel, liable for any of the following:

   - Intentional acts of minimum physical intervention, taking into account the total situation of the part of staff while responding to a disturbance initiated by me or by other individuals enrolled in services;
   - Self-inflicted injuries regardless of the circumstances;
   - Any injury or accident occurring during an unauthorized activity off campus;
   - Any injury or accident occurring during supervised activities (on or off campus) and unsupervised activities off campus if I am in a residential setting and have been given “off-campus privileges” as part of my treatment plan.

7. I understand that Excelsior uses email as a communication tool for tasks such as scheduling and updates. Email is **not** considered to be a form of counseling nor is it intended to replace in-person appointments, especially in crisis situations. If I find myself in a mental health crisis I can contact the following resources:

   - Spokane Region -24-Hour Crisis Line: 877-266-1818
   - North Idaho—Regional Mental Health Services: 888-769-1405
   - In life threatening situations dial 911

8. I understand that I am free to choose a healthcare provider who best suits my needs and goals. I am aware that I can end my services at Excelsior at any time.

Attestation of Informed Consent:

Information regarding our policies and procedures is provided to you as part of this informed consent. Please review these documents carefully and initial below. Your initial indicates you have reviewed, understand, and agree to the information provided.

I have reviewed and been provided a copy of Excelsior's Notice of Privacy Practices. _____ (initial)

I have reviewed and been provided a copy of my Individual Rights. _____ (initial)

I have reviewed and been provided a copy of the Grievance Procedure. _____ (initial)

I have reviewed and been provided a copy of the Assignment of Benefits. _____ (initial)

I have read and agree to the above information. I have been provided the opportunity to ask questions about this information, and I consent to healthcare and/or behavioral health services through Excelsior as outlined above.

_____ / _____ _____/_____/_____
Individual (print name) Signature Date

_____ / _____ _____/_____/_____
Parent/Guardian(print name) **(when applicable)** Signature Date

_____ / _____ _____/_____/_____
Excelsior Representative (print name) Signature Date