INOVA

3MHCNT

I. Information Provided:

I, _____, (Name of Patient or Designated Decision Maker) have been informed that the procedure or treatment to be performed is:

Therapy

Reason for procedure/diagnosis: To reduce feelings of distress and recommend appropriate level of care. Most psychotherapy is time-limited, goal-oriented and focused on problem-solving. Individual and group therapy is provided by psychotherapists who utilize the latest evidence-based treatment modalities. Therapy includes a range of non-medical treatments that can help with mental health problems, emotional challenges, and some psychiatric disorders. It aims to enable patients to understand their feelings, and identify what makes them feel positive, anxious, or depressed and provides coping skills or interventions in order to reach optimal mental health.

II. Documentation of Informed Consent

1. I understand that the **potential benefits and outcomes** of the proposed procedure or treatment include but are not limited to: **A significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. Behavioral Health treatment requires an active effort on my part. In order to be most successful, I will have to work on things that are discussed outside of sessions.**

2. I understand that the **potential risks and complications** associated with the proposed procedure or treatment include but are not limited to: **Experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of behavioral health treatment often requires discussing the unpleasant aspects of my life.**

3. **Alternatives** to the proposed procedure or treatment for my condition, including the benefits and risks of each and the option of no treatment, have been discussed with me. These include but are not limited to: **Referral to other services for care, testing, or no treatment. I have the right to stop the services at any time.**

III. Other

1. **Confidentiality, Care Coordination and Consultation:** The Health Insurance Portability and Accountability Act (HIPAA) governs how Inova can use and disclose my protected health information. Inova's policies about confidentiality, the ways that Inova will routinely use and disclose my protected health information, and other information about my privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. I have been provided with a copy of that document at registration and we have discussed those issues.

   There are some additional situations in which Inova is permitted or required to release my protected health information without my consent, including but not limited to:
   - If I am a danger to myself or to others;
   - If a court orders Inova to release certain information about me; and
   - If Inova has information that someone is being or has been abused or neglected.

   In all of these situations, Inova is only permitted to disclose the minimum amount of information necessary for the relevant purpose.

2. I understand that students, physicians in training, associates, assistants, and other personnel may participate in my care and treatment.

   ☐ I consent to students participating in my care and services.

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Behavioral Health Services

Informed Consent Form
Behavioral Health Therapy

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH
☐ IMG: _____

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IV. Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

V. Consent – Consent expires 1 year after latest signature.

I have had the opportunity to ask questions; and my questions have been answered to my satisfaction. I understand the risks, benefits, and alternatives associated with the proposed procedure or treatment. I consent to the procedure or treatment to be performed.

→ _____

Patient (signature) Date Time

The patient is unable to consent because: _____, therefore, I consent for the patient.

_____

Authorized Representative (signature) Date Time

Authorized Representative (print name): _____ **Relationship:** _____

Patient or Authorized Representative signature MUST be witnessed:

_____ _____

Witness (signature) Date Time **Witness** (print name)

I declare that I have personally explained the above information to the patient or the patient's designated decision maker.

_____ _____

Physician/Practitioner (signature) Date Time **Physician/Practitioner** (print name)

Consent by telephone obtained from:

_____ _____

Witness (Licensed Clinician) who has listened over the telephone (signature) Date Time **Witness** (print name)

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

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