SPRINTZ CENTER
FOR PAIN AND RECOVERY

CONSENT FOR INTENSIVE & SUPPORTIVE OUTPATIENT BEHAVIORAL & MENTAL HEALTH TREATMENT

1. **Consent to Evaluate/Treat**: I voluntarily consent that I will participate in a mental health (e.g. psychological, dietary or psychiatric) evaluation and/or treatment by staff from Sprintz Center for Recovery. I understand that following the evaluation and/or treatment complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment

    The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Texas Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, Dietary Services or Marriage and Family Therapy.

2. **Benefits to Evaluation/Treatment**: Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges**: Fees are based on the length on the type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. A copy of the fee agreement is available upon request.

4. **Confidentiality, Harm, and Inquiry**: Information from my evaluation and/or treatment is contained in a confidential record at Sprintz Center for Recovery, and I consent to disclosure for use by Sprintz Center for Recovery staff for the purpose of continuity of my care. Per Texas mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Discharge Policy**: There are circumstances under which I may be involuntarily discharged. I have read and understand the discharge policy of the clinic.

    Sprintz Center for Recovery may discontinue services if: (1) all treatment goals have been met; (2) you fail to demonstrate an interest in actively pursuing treatment goals; (3) you fail to pay for services as agreed upon in your Fee Agreement; or (4) upon the professional recommendation of your therapist.

6. **Right to Withdraw Consent**: I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

7. **Expiration of Consent**: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

____ ______________________
Signature of client ages 18 years or older or legal representative Date

____ ______________________
Authorized Provider Representative Date

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CONSENT FOR PATIENT EMAIL & MESSAGING

I confirm that I wish to communicate with Sprintz Center for Recovery, if given the option, by email/text and have read and understand the following information:

Risks of using Email/Text Messaging:

Transmitting patient information by email and/or text messaging has a number of risks that clients should consider prior to the use of email and/or text messaging. These include, but are not limited to, the following risks:

1. Email and text senders can easily misaddress an email or text and send information to an undesired recipient. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
2. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
3. Employers and on-line services have a right to inspect emails sent through their company systems.
4. Email and texts can be used as evidence in court.
5. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the use of email and text messages:

Providers at Sprintz Center for Recovery cannot guarantee, but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by the provider's intentional misconduct. Patients/parents/legal guardians must acknowledge and consent to the following conditions:

1. It is my request to use email/text.
2. Any decisions to use email/text communication will be discussed in staff supervision and an entry will be made into my electronic medical record.
3. I understand that email and text are not a secure way to communicate, and that this communication is not protected and the confidentiality of this communication cannot be guaranteed.
4. No emails/texts with urgent messages will be sent. Email and texting is not appropriate for urgent or emergency situations. Providers cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
5. When sending emails/texts I will not identify anyone by name.
6. All communications will be documented in my medical record.
7. It is my responsibility to inform the providers at Sprintz Center for Recovery of any changes in email addresses, mobile numbers or lost mobile devices as soon as possible.
8. Any decision by either me or the provider to stop the use of email/text will be respected. Any resumption will therefore require a new consent form.
9. Confidentiality will be respected by providers at all times.
10. Email and texts should be concise. The patient/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
11. All emails will be entered into the patient's electronic medical record; texts may be filed as well.
12. Patients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
13. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
14. It is the patient/parent/legal guardian's responsibility to follow up and/or schedule an appointment if warranted. I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the use of text messaging and emails. I understand the risks associated with the communication of email and/or text messaging between my provider and me, and consent to the conditions and instructions outlined, as well as any other instructions that my provider may impose to communicate with me by email or text.

____ _____________________
Signature of client ages 18 years or older or legal representative   Date

____ _____________________
Authorized Provider Representative   Date

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ACKNOWLEDGEMENT OF INTENSIVE OUTPATIENT PROGRAM BINDER RECEIPT

The Sprintz Center for Recovery Intensive Outpatient Program Binder contains information that will help you navigate your IOP treatment, be aware of your rights as well as the expectations of SCR staff, and provide you with educational and treatment materials to assist with your recovery. If you have any questions about binder contents, please ask an SCR staff member. The IOP program binder includes, but is not limited to, the following important documents and content areas:

- First Steps: Beginning Your IOP Treatment
- Patient Rights and Responsibilities
- What is IOP? Explaining Levels of Care
- Frequently Asked Questions • The Sprintz Center Experience: An Introduction to Our 6 Core Program Components
- IOP Program Schedule
- Individual Consultations
- Serving You Best: Our Communication with Outside Care Providers
- Program, Group, and Mealtime Rules and Expectations • Meal Challenges
- Consequences of Failing to Meet Rules and Expectations
- Safety Plan: What to Do In Case of Emergency
- Program Content (from Our 6 Core Program Components)
- Yoga for Eating Disorder Recovery • A Little Bit More: Supplementing Your IOP with Additional Groups
- Am I Ready for Discharge? Criteria for Moving to a Lower Level of Care
- What's Next? Continuing Your Recovery After Discharge from IOP
- Resources
- How to Reach Us or Access Your Records

Please sign below acknowledging that you have read and agree with this material.

I hereby acknowledge receiving a copy of the patient program binder and I understand that it is my responsibility to review the rules, patient rights and responsibilities and the grievance procedures and to ask questions for clarification, if needed. I agree to follow these rules to the best of my capability and ask for help when needed. I acknowledge that I may choose to take my binder home with me or store it safely in a secure area at Sprintz Center for Recovery until the termination of my treatment. I agree that if I choose to take my binder home with me, I am responsible to bring it back for the next day of treatment. I agree that if I lose or damage my binder and need to replace it, I will be required to pay $25.00 to obtain a new one. I understand that because participation in the IOP requires that I have my binder, replacing a lost or damaged binder and paying to do so is not optional.

Signature: ____ Date: _______________________

Staff Witness: ____ Date: _______________________

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INTAKE PAPERWORK CHECKLIST

Please initial that you have read, reviewed, and understand the following paperwork, and have had all of your questions answered regarding what you are signing today.

(please initial)

______ Consent for Intensive Outpatient/Outpatient Mental Health and Dietary Treatment

______ Fee Agreement

______ Clinic information Policies and Procedures

______ History and Background

______ Joint Notice of Privacy Practices

______ Patient Rights and Responsibilities

______ Consent for Patient Email and Text Messages

______ Copayment Form for IOP services

______Acknowledgement of IOP program binder receipt

______ IOP No Show/Late Cancellation Policy

By signing this form, I acknowledge that I have read, reviewed, and understand the forms that I have signed and have had all of my questions answered by a member of the Sprintz Center staff.

Signature: ____ Date: _______________________

Staff Witness: ____ Date: _______________________