GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER		
TITLE: Informed Consent for Evaluation, Treatment and Services	**POLICY NO:** AD-PA-105	Page **1** of **3**
RESPONSIBILITY: Agency Wide		
APPROVED BY: _____ THERESA C. ARRIOLA, DIRECTOR	**DATE OF ORIGINAL APPROVAL:** 10/16/1990	
	LAST REVIEWED/REVISED: 1/27/20	

PURPOSE:

To provide a process of obtaining informed consent and ensuring that a consumer or a consumer's legal guardian is provided with information of the potential risks and benefits of a treatment, probable consequences of each treatment, and other alternative options associated with recommended treatment.

POLICY:

A. GBHWC upholds the informed consent doctrine that a physician and other qualified mental healthcare providers providing treatment intervention, has a legal, ethical, and moral duty to respect consumer autonomy and to provide only such mental health treatment as authorized by the consumer.

B. An admission informed consent must be obtained from all voluntary and civilly committed consumers upon intake, who are competent to give informed consent by signing the Informed Consent Form FAD-PA-05.1 which outlines the routine services, diagnostic assessments and everyday routine or necessary physical contact with the consumer to include PCM restraint if appropriate.

C. The legal guardian or next of kin's consent, as well as assent of the consumer should be obtained if the consumer is a minor or is mentally incapacitated.

D. An implied consent will generally be presumed in a psychiatric emergency situation when immediate action is required to prevent death, permanent impairment of a consumer's health, a serious and immediate danger to life, health or safety of the consumer and of others.

DEFINITIONS:

Informed Consent: a legal doctrine that requires a consumer have a full understanding of that to which he or she has consented, which includes information on potential risk and benefits of a proposed treatment and possible alternatives to such treatment.

Psychiatric Emergency: A temporary period during which, by reason of a person's state of mental illness, there is serious and immediate danger to life, health, or safety of the person and or others.

Emergency Treatment: Is any treatment whose omission or interruption would lead to worsen, or prolong a psychiatric emergency, and which is deemed capable of modifying or terminating the state of mental illness which causes the psychiatric emergency.

Non-Emergency treatment: Is any treatment whose omission or interruption would not lead to, worsen, or prolong a psychiatric emergency.

PROCEDURE:

A. The basic element of informed consent are as follows;
   1. A fair explanation of the procedures, assessments, treatment planning, interventions to be followed, together with their purpose.
   2. A description of any attendant discomforts and risks reasonable expected.
   3. A description of any benefits reasonable to be expected
   4. An offer to answer any inquiries concerning the procedure.
   5. Instruction that the consumer is free to withhold or withdraw consent and to discontinue participation at any time.
   6. A disclosure of any appropriate alternative intervention or treatment that may be advantageous for the client.

B. Initiation of Informed Consent Upon Admission
   1. In order to make an informed consent, the consumer shall be given sufficient information by the intake worker and Lead Provider regarding assessments, treatment planning and possible interventions to include the different platform these interventions can be provided; such as traditional face to face encounter, home visits and or telehealth video conferencing.

   2. If consumer agrees with the proposed treatment, the *Informed Consent Form AD-PA-05.1* must be signed and will be valid for 1 year. The completed form shall be placed in the consumer records and a copy given to the consumer. Once the informed consent expire, the Lead Provider shall again update the informed consent form.

   3. In a psychiatric emergency an implied informed consent shall be presumed, for evaluation and treatment and in administering emergency psychotropic medication. Once the psychiatric emergency is resolved, an informed consent shall be obtained from the consumer for any further treatment and or intervention that will ensue. Consent to psychotropic medication shall also be obtained utilizing *FCL-NSD-04 Consent to Psychotropic Medication* form if psychotropic medication is initiated (*see CL-NSD-04 Consent to Psychotropic Medication*).

   4. If a consumer withdraws consent to treatment, and treatment team decides to continue treatment on an emergency basis, documentation should indicate the nature of the emergency, the treatment, and management strategies to be used.

C. Informed consent for consumers with legal guardianship or conservatorship
   1. The legal guardian's informed consent for evaluation and treatment shall be obtained in place of the consumer's under the process indicated in this policy.

   2. An assent to treatment by the minor, incapacitated consumers with legal guardianship must be documented in the medical record prior to getting the legal guardians consent.

D. Consent to Psychotropic Medication
   1. Specific informed consent for psychotropic medication initiation or administration shall be obtained by the Psychiatrist prior to prescribing medication (*reference CL-*

NSD-04 Consent to Psychotropic Medication). A reasonable description of any controlled substances and any other drugs to be used, and their anticipated effects, side effects, and interactions.

SUPERSEDES

Informed Consent to Treatment; Marilyn L. Wingfield. Oct.16, 1990.

REFERENCE(S):

ATTACHMENT(S):
F-AD-PA-05.1 Informed Consent for Evaluation and Treatment Services

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790 Gov. Carlos G. Camacho Rd. Tamuning, Guam 96913
TEL: (671) 647-5330 FAX: (671) 649-6948

INFORMED CONSENT FOR EVALUATION, TREATMENT AND SERVICES

CONSUMER NAME: _____ **DOB:** _____ **AGE:** _____
MR # _____ **DATE OF CONSENT** _____ **EXPIRATION DATE:** _____
LEGAL GUARDIAN NAME: _____

Consent to Evaluate/Treat: I voluntarily consent that I /my child/ward will participate in mental health evaluations, treatment, and/or services by professional staff from the Guam Behavioral Health and Wellness Center (GBHWC). I understand that following the evaluation and assessment a complete and accurate information will be provided concerning the benefits and risk of the proposed treatment intervention/service.

Consent to Telehealth Services. I voluntarily consent that I/my child / ward shall participate in Telehealth services such as videoconferencing, in the event that a traditional direct face to face encounter is not feasible and if clinically appropriate. I understand the video conference technology will be used for my behavioral health services and this will not be the same as traditional face to face contact as I will not be in the same room as the provider. Telehealth Videoconferencing will not be recorded, and taking of photograph is prohibited. I understand my information will be shared with other individuals for scheduling and set-up of the video conferencing appointments, however these individuals will maintain confidentiality per agency protocols. I have been informed if emergent issues are a concern, the video conferencing will end and crisis services will be provided.

Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with interviews, assessments, testing, medication management, and other evidence based practices. It may be beneficial to me/my child/ward 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 services include diagnosis, evaluation of recovery or treatment, and rehabilitation planning. Possible benefits to treatment include improved cognitive performance, health status, quality of life, and awareness of strengths and limitations. I understand that my mental health provider cannot guarantee results (e.g., less depressed, less anxious, improved marital satisfaction, etc.) of services. However, there will be clearly stated reasons, goals and objectives for continuing/discontinuing any treatment.

Risk: I understand that there may be some risks in participating in behavioral health services. These may include, but are not limited to, addressing painful emotional experiences and/or feelings; being challenged or confronted on a particular issue; or re-uniting with family members. In case of psychiatric care, medication side effects, and alternative treatments will be discussed by the Psychiatrist.

Charges: Fees are based on the length or 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 and may apply for the Sliding Fee Discount if eligible. Fees are available to me upon request.

Confidentiality: Information from my/my child's/ward evaluation, treatment, and/or services is contained in a confidential mental health record at GBHWC, and I consent to disclosure for use by GBHWC staff for the purpose of continuity of my care. I understand my provider(s) may need to discuss

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my protected health information (PHI) in a confidential manner with other GBHWC professionals for the purpose of providing quality treatment and services. I am aware that additional professional staff may be asked to participate in the evaluation and treatment. I understand my PHI will be kept confidential unless I authorize that information be released or unless allowed by law. These exceptions to confidentiality are referenced in the Notice of Privacy Practices handout. I also understand that audio and video recording as well as photographing during the session is prohibited.

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 my Lead Provider or treatment team.

Expiration of Consent: This consent is valid for 1 year and will expire under a few conditions, including but not limited to:

1. You / Your child / Your ward, miss an appointment and do not respond to the staff's outreach efforts within a specified time frame,
2. You /Your child / Your ward do not request or have not receive services for a continuous period of ninety (90) days,
3. You / Your child / Your ward relocate off island for more than ninety (90) days,
4. You / Your child / Your Ward do not need further treatment/services (i.e., completed treatment, stable, etc.)
5. You / Your child / Your ward, choose non-GBHWC services provider,
6. You/ Your child / Your ward, refuse or chose to disengage in services by notifying the Center in writing.

Rights and Responsibilities: I acknowledge that I have been informed, understand, and have been given a copy of the Statement of Consumer Rights and Responsibilities.

By signing below, I have read and understand the above, have had an opportunity to ask questions about this information, and I voluntarily consent/ I voluntarily consent for my child /ward to participate in mental health evaluations, treatment, and services at the Guam Behavioral Health and Wellness Center (GBHWC). I understand that I have the right to ask questions about the above information at any time.

*(*Note: GCA Ch. 19 allows consumers eighteen (18) years or younger, consenting to services that involve pregnancy related issues, HIV/AIDS/STDS, or substance abuse treatment, to sign this consent form)*

☐ I consent to Telehealth services, and to traditional direct face to face consumer provider contact.

☐ I don't consent to telehealth services, but give consent to traditional direct face to face consumer provider contact.

Signature of Consumer/Legal Guardian _____ Date _____

Witness Printed Name _____ Witness Signature _____ Date _____

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REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

Policy Title: Informed Consent for Evaluation and Treatment Services
Policy No: AD-PA-105
Initiated by: Cydsel Toledo

Date	Signature
7-20-2020	

Marilyn Aflague
Administrative Service Officer- Patient Affairs

Date	Signature
7.23.20	

Ms. Annie Unpingco LCSW,LPC
Child Adolescent Services Division Administrator

Date	Signature
7/22/2020	

Reina Sanchez, M.A
Clinical Administrator

Date	Signature
7/22/2020	

Dr. Ariel Ismael
Medical Director

Date	Signature
7-20-2020	

Leonora Urbano MSN, RN-BC
Nursing Administrator

Date	Signature
7/24/2020	

Carissa Pangelinan
Deputy Director

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