

Comprehensive Behavioral Health Management/College Health IPA Policy and Procedure Manual	
Policy Name: Informed Consent	Patient Rights and Responsibilities
Date: 05-06 Reviewed by QI Committee: 7-06, 07-07, 07-08 Revised by QI Committee:	Page: 1 of 3 Policy Number: RR-7

Purpose: To ensure that patients receiving behavioral health services from College Health IPA contracted providers are informed regarding the benefits and risks associated with all treatment services and that they have given informed consent for treatment to proceed.

Policy

1.0 Identifying Who May Give Informed Consent

- 1.1 Capacity to Give informed consent. An adult (persons ages 18 and over) may give a valid informed consent only if he or she has “capacity” which means he or she is able to understand the nature and consequence of a decision and to make and communicate the decision. If an adult lacks capacity, a surrogate decision maker should be identified (e.g., specified in an Advance Directive, Medical Power of Attorney, etc.).
- 1.2 Minors. In general minors (persons aged 17 and under) may not give informed consent for behavioral health care. Parents, legal guardians, or a designated third party (written designation given by parent or legal guardian) must give informed consent for the minor. Only in the situations below may a minor give informed consent for behavioral health care.
 - 1.2.1 Minor is emancipated – declaration by court, identification card from DMV)
 - 1.2.2 Minor is self-sufficient (15 or older, not living at home, manages own financial affairs)
 - 1.2.3 Minor is on active duty with the military
 - 1.2.4 Minor is 12 or older and seeking treatment for rape
 - 1.2.5 Minor is 12 or older and seeking treatment for drugs or alcohol
 - 1.2.6 Minor is 12 or older and seeking outpatient mental health treatment
- 1.3 Emergency Exception. When informed consent cannot be obtained (e.g., adult lacks capacity and no surrogate decision maker available or a minor does not have a guardian available) and treatment is immediately necessary to prevent harm to self or others, treatment may proceed.
 - 1.3.1 Emergency treatment without informed consent must be limited to that which is necessary to resolve the emergency.
 - 1.3.2 Documentation must include any attempts to obtain informed consent and the nature of the emergency, which required proceeding with treatment.

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1.3.3 After resolution of emergency, ongoing treatment requires informed consent.

2.0 Procedures Requiring Informed Consent

- 2.1 All behavioral health services provided to resolve a mental health or substance abuse disorder require informed consent.
- 2.2 All prescriptions of psychotropic medications require informed consent.

3.0 Responsibility for Informed Consent

- 3.1 The clinician providing services is responsible for providing and explaining the information a patient needs to make informed consent.
- 3.2 The Informed Consent documentation is to be signed by the patient, guardian, or surrogate decision maker after the treating clinician has verbally reviewed the information and confirmed comprehension.
- 3.3 The Informed Consent documentation is to be signed by the treating clinician acknowledging that he or she reviewed the information and confirmed comprehension.

4.0 Content for Informed Consent

- 4.1 The topics that are to be included in all Informed Consent documentation are:
 - 4.1.1 The nature of the treatment (e.g., explanation of therapy or medication management process)
 - 4.1.2 Potential benefits, risk, or side effects of the treatment, including any potential setbacks that might occur
 - 4.1.3 The likelihood of achieving treatment goals
 - 4.1.4 Reasonable treatment alternatives (e.g., self-help programs)
 - 4.1.5 The possible result of not receiving treatment
 - 4.1.6 Any limits on confidentiality (e.g., mandated reporting)

5.0 Obtaining and Documenting Informed Consent by Telephone, Facsimile, and Email

- 5.1 It may be necessary to obtain informed consent from a person who is not physically present at the initial assessment (e.g., guardian not available). In these circumstances, the clinician may choose one or more of the following options:
 - 5.1.1 Attempt to reach responsible party by telephone and fully review the information with another witness listening in. Document in

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medical record the telephonic review and include signatures of the clinician and witness.

5.1.2 Fax all the appropriate documentation to the responsible party and request that he or she sign and return by fax.

5.1.3 Email the appropriate documentation to the responsible party and request that he or she reply by fax. Print out reply acknowledging informed consent and include in medical record.

5.2 Whenever informed consent is obtained via phone, facsimile, or email, the clinician is encouraged to seek original signature at the time the responsible party becomes available.

6.0 Refusal of Treatment

6.1 Patients have the right to refuse recommended treatment. It is the responsibility of the treating clinician to explain the benefits and risks of refusing treatment.

6.2 Patient's refusal is documented in the medical record along with a statement from the treating clinician acknowledging that the consequences of the refusal decision were explained.

6.3 If the individual refusing recommended treatment is a parent, guardian, or surrogate decision maker, the clinician examines the impact on patient. A child or dependent adult abuse report is filed if there appears to be medical neglect resulting in potential danger to self or others.

6.4 Following a refusal, the treating clinician determines whether or not to continue care with the patient. If care is to be discontinued the clinician documents

6.4.1 Recommended care refused

6.4.2 Explanation of potential consequences of refusal

6.4.3 Explanation of treatment termination

6.4.4 Alternative treatment referrals given