CHESTNUT
HEALTH SYSTEMS

INFORMED CONSENT / CONSENT TO TREATMENT

We thank you for choosing Chestnut Health Systems, Inc. for your treatment services. At Chestnut we strive to equip people with the tools they need to meet challenges and improve their quality of life. This document contains important information about your treatment services at Chestnut. Please ask questions about anything you do not understand.

INFORMED CONSENT

Behavioral healthcare services have benefits and risks. Treatment services can help you learn about yourself, manage your life and relationships, gain and maintain hope and a sense of well-being, and have various other positive effects on your life. However, because treatment services often involve working through difficult aspects of your life, you may experience uncomfortable feelings such as sadness, anger, guilt, frustration, or other difficult emotions.

Your first visit(s) will involve an assessment of your needs, followed by recommendations for your treatment. You will then work with Chestnut staff to develop a treatment plan that will outline your goals for treatment and a plan for achieving them. Your regular attendance and active participation is essential in order to obtain maximum treatment benefits.

CONSENT TO TREATMENT

I am voluntarily seeking services from Chestnut for the purposes of behavioral health diagnosis and treatment and hereby consent to such diagnostic procedures and treatment as may be deemed necessary for myself or, in my capacity as legal guardian, for the patient. I understand that Chestnut's facilities are not locked treatment facilities. I acknowledge that sufficient information concerning the nature and purposes of Chestnut treatment programs, its procedures, and methods of treatment have been explained to me in order for me to make an informed decision about my treatment. I authorize Chestnut staff to determine the treatment methods necessary for me to be successful in treatment.

I understand that my health information may be accessible to Chestnut employees in the course of their duties, whether or not I am an employee or family member of a Chestnut employee or have a personal relationship with a Chestnut employee. Employee or family member health information will be treated the same as other health information received by Chestnut.

I understand that I have the right to give or withhold informed consent regarding treatment. I understand that while I may withdraw my consent to treatment at any time, if I do so, I will be discharged from services.

My signature below is acknowledgment that I have received, read and understand this Informed Consent/Consent to Treatment document and I hereby voluntarily consent to treatment at Chestnut.

Signature of Client and Date (required for clients age 12 & older)	Signature of Guardian and Date (parent or legal guardian, as applicable)
Witness Signature and Date	Signature of Family Member and Date (optional)

Client Name:	Client ID: