CHESTNUT HEALTH SYSTEMS

INFORMED CONSENT / CONSENT TO TREATMENT (MISSOURI)

Welcome to Chestnut Health Systems, Inc. (hereafter called "Chestnut"). This document contains important information about treatment services. Please ask questions about anything you do not understand.

Informed Consent
Behavioral healthcare services have benefits and risks. As a participant in services, what you will experience cannot be predicted.

Treatment services can have benefits for those who participate. Services can help you to learn about yourself, manage your life and relationships, gain and maintain hope and a sense of well-being, or have other positive impacts on your life.
Alternatively, since 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 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 to obtain maximum treatment benefits.

Consent to Treatment
I am voluntarily seeking services from Chestnut for the purposes of diagnosis and treatment, and do 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 am aware that mental health and substance abuse counseling is not an exact science and acknowledge that no guarantees have been made as to the result of diagnosis, treatment, tests, or examination.

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

I further understand that if I am an employee or family member of an employee of Chestnut or Chestnut Family Health Center ("CFHC") my health information may be accessible to other employees in the course of their duties. Employee or family member health information will be treated the same as other health information received by Chestnut or CFHC.

My signature below is acknowledgment that I have received, read, and understand this Informed Consent/Consent to Treatment document.

Signature of Consumer and Date (required for consumers age 12 & older)	Signature of Guardian and Date (parent or legal guardian, as applicable)
Witness Signature and Date (clinical staff required for mental health services)	Signature of Family Member and Date (optional)

Consumer Name:	Consumer ID Number: