CHESTNUT HEALTH SYSTEMS

# INFORMED CONSENT / CONSENT TO TREATMENT / PATIENT RIGHTS / TELEHEALTH (MO)

**Patient Name:** **Date of Birth:**

Thank you for entrusting Chestnut Health Systems, Inc. ("Chestnut") with your healthcare needs. 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 services at Chestnut. Please ask questions about anything you do not understand.

## INFORMED CONSENT

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, treatment services may involve working through difficult aspects of your life and you may experience uncomfortable feelings such as sadness, anger, guilt, frustration, or other emotions.

Your first visit(s) may 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 voluntarily seek services from Chestnut for the purposes of healthcare diagnosis and treatment. I hereby consent to mental health and behavioral health evaluation, diagnosis, and treatment as may be deemed necessary for myself or, in my capacity as legal guardian, for the patient.
I understand and acknowledge the following:

- Chestnut's facilities are not locked treatment facilities.
- Information concerning the nature and purposes of Chestnut's programs, procedures, and treatment methods has been explained to me in order for me to make an informed decision.
- Treatment may include psychiatric, psychological, counseling, or behavioral health interventions.
- I authorize Chestnut staff to determine the treatment methods necessary for me to be successful in treatment.
- My health information may be accessed only by Chestnut workforce members as necessary for treatment, payment, and healthcare operations, consistent with the "minimum necessary" standard under applicable law.
- This site is a teaching facility and may include physicians, nurse practitioners, behavioral health clinicians, residents, fellows, students, and other professionals in training.
- I have the right to withdraw consent at any time. I understand that withdrawal of consent may result in discharge from services, except as otherwise provided under applicable law.

## CONFIDENTIALITY AND PRIVACY

I understand that my records are protected under the following laws and regulations and cannot be disclosed without my written consent except as otherwise specifically permitted:

- Health Insurance Portability and Accountability Act ("HIPAA")
- 42 CFR Part 2 (Confidentiality of Substance Use Disorder Patient Records), if applicable
- Missouri Code of State Regulations
- Missouri Department of Mental Health
- Other applicable federal and state laws protecting patient privacy

Disclosures without consent are permitted only in limited situations, such as medical emergencies, reporting of child or elder abuse/neglect, certain court orders, and certain other instances as required by law.

## TELEHEALTH CONSENT

I understand that treatment services may be delivered through telehealth (telephone, video conferencing, or other secure electronic means). I acknowledge the following:

- Telehealth will be conducted in a private and secure manner, consistent with HIPAA, 42 CFR Part 2, Missouri Department of Mental Health, and Missouri law.
- I have the right to refuse telehealth services and request in-person care, except in emergencies or when public health circumstances require otherwise.
- I understand that telehealth may have limitations compared to in-person care, including potential technology failures, interruptions, or limited ability to perform certain assessments.
- I agree to participate in telehealth services in a private location and to protect my own confidentiality.

- I understand that I may withdraw consent for telehealth at any time without affecting my right to future care.
- I understand that my provider will document my physical location at the time of each telehealth service and may initiate emergency services if necessary.
- In the event of a technology failure or emergency, Chestnut may contact local emergency services or use alternative communication methods.
- I understand that telehealth services may be billed to me or my insurance similar to in-person services.

My consent to telehealth includes primary care, mental health, behavioral health, counseling, medication management, and other healthcare services deemed necessary.

**COMMUNICATION PREFERENCES AND ELECTRONIC COMMUNICATION CONSENT**

I understand that Chestnut may communicate with me regarding my care, appointments, treatment coordination, billing, and other healthcare-related matters using various methods of communication. I acknowledge that some methods, particularly electronic communications, may carry privacy risks. I voluntarily choose my preferred method(s) of communication below and understand that I may update or revoke these preferences at any time by notifying Chestnut in writing.

I consent to be contacted by Chestnut using the following method(s):
(check all that apply)

☐ Phone call (voice message may be left)
☐ Text message (SMS)
☐ Email
☐ Patient portal / secure electronic messaging
☐ U.S. Mail
☐ Do not contact me

I understand that text messages and emails may not be encrypted and could be accessed by others with access to my phone, email account, or device. By selecting these options, I acknowledge and accept these risks. I understand that Chestnut will make reasonable efforts to use my preferred communication method(s) but may use alternate methods when necessary for treatment, payment, healthcare operations, emergencies, or as required by law. I understand that I may withdraw or change this consent at any time, and that doing so will not affect my right to receive services.

**PRIVACY PRACTICES AND PATIENT RIGHTS**

I acknowledge that I have received Chestnut's Patient Rights statement, which includes, but is not limited to:

- The right to be treated with dignity and respect.
- The right to participate in treatment planning and decision-making.
- The right to refuse treatment, consistent with law.
- The right to confidentiality of records, subject to federal and state laws.
- The right to be free from abuse, neglect, or exploitation.
- The right to file a grievance regarding services without retaliation.
- The right to receive conflict free treatment
- The right to file a grievance with the Missouri Department of Mental Health.

For questions about Privacy Practices or Patient Rights, I may contact: Privacy Officer, 1003 Martin Luther King Drive, Bloomington, IL 61701, 309.827.6026, or privacy@chestnut.org.

***My signature below is an acknowledgment that I have received, read and understand this Informed Consent/Consent to Treatment document, and I hereby voluntarily consent to treatment at Chestnut (including telehealth, if applicable), and that I have received and understand Chestnut's Patient Rights. I further acknowledge that I have received orientation and documentation to Chestnut Health Systems Missouri Services and Program Requirements.***

| **Patient Signature** | **Date** |
|---|---|
| **Patient Parent/Guardian Signature** *(if applicable)*<br>**Relationship if not Patient:** ☐ Parent ☐ Legal Guardian ☐ Power of Attorney | **Date** |
| **Witness Signature** | **Date** |