

**RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH
TBS INFORMED CONSENT AND CONSENT TO TREATMENT**

Informed Consent/Limits to Confidentiality

Therapeutic Behavioral Services (TBS) is an intensive Mental Health Service, which utilizes a collaborative team approach. As such, information regarding the TBS case for you and your family may be shared with other TBS Treatment Team members. Treatment Team members may include, but not limited to, employees of the Department of Mental Health, Department of Public Social Services, Probation, your Therapist, Family/Caregiver/Group Home Staff, and the TBS Coach and Clinical Supervisor. Releases of information must be signed by a parent/guardian to allow these Treatment Team members to discuss your case with anyone else.

All Treatment Team members are Mandated Reporters. This means that under the laws of the State of California, these members are required to report information to the police or other government social service agencies regarding the following situations:

- Incidents revealed about child abuse, whether actual or suspected including physical abuse, sexual abuse, and neglect;
- Incidents revealed about dependent adult or elderly abuse including physical abuse, sexual abuse, neglect, abandonment and fiduciary abuse;
- Threats to harm self or others.

If you make statements regarding any of the above topics to any member of the Treatment Team, reports will be made to the appropriate agency as required by law.

Consent to Treatment

I understand that I am expected to benefit from treatment through Therapeutic Behavioral Services (TBS), but there is no implied or expressed guarantee that I will.

I also understand that I have the right to terminate treatment at anytime. I understand that I also have the right to refuse to implement any recommendations, psychological interventions, or any treatment procedure.

I consent and agree voluntarily to receive psychological services from Riverside County Department of Mental Health through TBS. Services I receive may include, but are not limited to: diagnostic assessments, behavioral coaching, crisis intervention, consultations and referrals to other professionals.

Acknowledgement of Understanding and Receipt

I, the parent/legal guardian of _____ D.O.B. _____ do agree that Therapeutic Behavioral services (TBS) are needed for my child on a short-term basis to address behaviors/symptoms which put him/her at risk of placement or hospitalization. I understand that I must work closely with the clinician for my child and the TBS provider to make a plan for these services to be delivered to my child. At any time, I can request a change in the service or termination of the service through a discussion with my clinician and TBS provider.

I have read the above information and by signing below I am stating that I understand and agree to the above information regarding: Informed Consent/Limits to Confidentiality and Consent to Treatment.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____