newvista

Client Consent Form

Welcome to New Vista!

We're grateful you've chosen us to partner with you on your path to recovery, wellness, and improved well-being. New Vista is committed to providing compassionate, person-centered, trauma-informed, and culturally responsive care.

As a Certified Community Behavioral Health Clinic (CCBHC), we offer integrated mental health, substance use disorder, and physical health services designed to support you as a whole person. Our goal is to ensure that you feel informed, respected, and empowered as we work together.

The purpose of this form is to outline your services and ensure we have your permission to conduct treatment and to ensure you are fully informed of what that will involve, including risks and limits of our work together.

1. Informed Consent for Services and/or Treatment

I understand that New Vista is providing behavioral and/or physical health assessment and treatment services to me. I understand that there are no certain outcomes from these services and that individual experiences with treatment may vary.

I understand that services may be provided to me in-person and/or via telehealth. I understand that services may be provided by a multidisciplinary team which could include physicians (psychiatrists, primary care providers), nurse practitioners, clinicians, as well as other behavioral health and medical professionals.

New Vista is a Certified Community Behavioral Health Clinic (CCBHC), which provides integrated health care services. To improve the quality of services, I understand that I will be asked to complete a data collection interview at the beginning of services, and every 6 months until I no longer receive services. The interview will include questions about the services, behavioral health experiences, physical and mental health, and recovery. The information will be kept private and only de-identified information will be shared with the State of Kentucky and the Substance Abuse Mental Health Services Administration.

I am aware that New Vista has a duty to protect my confidentiality except where the law requires disclosure of certain information. There are several situations in which New Vista cannot assure confidentiality including:

- **New Vista** has a duty to report the abuse, neglect or exploitation of a vulnerable adult to the Department for Community Based Services;
- **New Vista** has a duty to report any instance of child neglect, exploitation or abuse to the Department for Community Based Services and/or the police;
- **New Vista** has a duty to report any threats against persons to the intended victim and to the police;

- **New Vista** has a duty to report domestic violence/abuse and/or dating violence/abuse to law enforcement if requested by a client or if a staff member believes the death of a client may be related to domestic violence/abuse and/or dating violence/abuse;
- **New Vista** has a duty to release information to agencies or persons with a need to know when a client needs hospitalization; and when a client introduces personal mental health or substance use issues in court proceedings then confidentiality is waived by the client.

Understanding all of the above possible waivers of confidentiality, I give consent to New Vista and its clinicians, nurse practitioners, physicians and other providers to provide assessment and treatment services to me. I give consent to New Vista medical staff and care coordinators to electronically access third party medication history information and to contact pharmacies to clarify medication orders when necessary for my clinical care.

I understand that if I am not paying the full fee as shown on the schedule of fees, part of it will be paid by the Commonwealth of Kentucky and information from my record will be made available to the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities. This will include my social security number, diagnosis, problem areas, recent history of services and events that may have led to services.

Federal rules prohibit any party from making further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

I have been given a copy of the Client Service Guide, the Client Bill of Rights, the Complaint/Grievance Procedures, and the Notice of Privacy Practices. I had the opportunity to ask questions about treatment, and I consent to New Vista's services.	☐Yes	☐No

2. Use of Technology in Documentation

As part of our commitment to providing high-quality care and efficient service, we may use advanced documentation tools to assist in writing clinical documentation. These tools are designed to support accurate and timely record-keeping while maintaining your privacy and the integrity of your care. During sessions, with your permission, we may enable an ambient listening feature that assists with real-time documentation. This technology does not record or store your conversation; it simply processes spoken words to generate summary statements the clinician can use in their treatment notes. Use of this feature is entirely optional, and you may decline by checking the 'Opt Out' box below. If you do not opt out, your signature on this document indicates your consent to its use. Opting out will not affect the quality of your care or our ability to document your treatment effectively. Please note that any technology is subject to occasional inaccuracy or limitations, but all final decisions about your treatment, care, and documentation are made by trained professionals, not by the technology. If you have any questions about how this technology is used, please let us know.

☐ I want to **opt out** of the ambient listening feature.

3. Signature & Acknowledgments

I have read and understood the previous sections of this treatment consent, including 1.) Consent for Treatment from New Vista; and 2.) The Use of Technology for Documentation Purposes.

Client Name (print): _____ **DOB:** _____

Client Signature: _____ **Date:** _____

Name of guardian, if applicable (print): _____

Guardian Signature: _____ **Date:** _____

As the mental health or medical provider for this client, I have explained this form to the client and answered their questions, if any. In my professional judgment, they are capable of making and have made an informed decision to accept treatment services.

_____ _____

Signature of Provider with Credential **Date**