# Informed Consent for Assessment/Treatment

You have been referred to Transitional Care Management, LLP (TCM) by the Bureau of Prisons (BOP). You will be seen by providers contracted by TCM. This consent for treatment applies to the BOP. If you are also residing at the halfway house or you are on home detention through the halfway house, this release also applies to the halfway house. In this release form, the BOP and the halfway house will be referred to collectively as the Department.

1. **Relationship with Referring Agency:** I agree that Transitional Care Management, LLP is providing treatment to me so that I can fulfill my obligation to the Department's requirements and consequently, I do not expect to have confidentiality with the providers of Transitional Care Management, LLP nor do I expect them to be my advocate. I agree that the providers of Transitional Care Management, LLP and Department are working as one, to help keep the community safe.
2. **Purpose of Treatment:** I agree that the purpose of treatment is to help me change my thinking, emotions, relationships, personal characteristics, and behaviors, so I can achieve and maintain abstinence, manage my mental health, and adjust to the community.
3. **Nature/Procedure of the Services**: I agree to participate in an assessment, individual, group and family therapy, and/or medication management as directed by the providers of Transitional Care Management, LLP. I agree that the services offered are rehabilitation services, i.e., interventions designed to reduce the chance that I will engage in substance abuse or criminal activity. Or, if recommended, I will be receiving mental health treatment for such things as depression, anxiety, schizophrenia, etc.
4. **Goal of the Services**: I agree that the primary goal of treatment is to achieve and maintain abstinence, manage my mental health, avoid the criminal lifestyle, and adjust to the community. I agree that by participating in treatment with providers of Transitional Care Management, LLP I can comply with my conditions of supervision and complete mandated treatment. I understand that Transitional Care Management, LLP therapists are not my advocates and their goal is to assist the Department and help me achieve and maintain abstinence and stability.
5. **Personal Control**: I understand that I do not have to participate in an assessment or treatment unless I want to. I understand that I can withdraw from treatment at any time by giving Transitional Care Management, LLP written notice that I want to withdraw from treatment.
6. **Lack of Confidentiality:** I understand that anything and everything that I say, write, do, or convey to providers at Transitional Care Management, LLP may be conveyed by them to the Department.
7. **Permission to Communicate**: I agree to allow Transitional Care Management, LLP to have written, verbal, electronic, telephonic and fax contact with the Department. I understand that anything I say, write, do, or convey to the providers at Transitional Care Management, LLP may be communicated to the Department. I understand that at a minimum, Transitional Care Management, LLP will be providing the Department with written notices of my progress, success, and violations.

8. **Possible Side Effects of the Intake – Potential Benefits:** I agree that I can meet the requirements set forth by the Department by participating in treatment with providers at Transitional Care Management, LLP. I agree that I can learn about myself through treatment and I might be able to improve my life. I understand that if I succeed in treatment, I could become more happy and successful. I agree that there might be additional benefits that are unique to my situation.
9. **Possible Side Effect of the Intake – Potential Risks:** I understand that there are no overt or implied guarantees with regard to treatment or the outcome of treatment. I understand that I might feel unpleasant emotions during the time that I am in treatment. I understand that I might reveal information that could warrant a legal response, e.g., abuse of an elderly person, child or disabled person. I understand that anything that I say, write, do, or convey to providers at Transitional Care Management, LLP may be used against me by the Department or in a court of law. I understand that some parties might try to use the information gathered during the intake or treatment against me in a court or legal setting. I agree that there might be other risks that are unique to my situation.
10. **Use of an Attorney:** I agree that at any point in the treatment process, I can consult an attorney. I agree that I can consult an attorney before I receive treatment from providers of Transitional Care Management, LLP. If I do receive treatment from Transitional Care Management, LLP and I do sign this form, I am indicating that I am receiving treatment from providers of Transitional Care Management, LLP of my own free will and I do not want to talk to attorney at this time.
11. **Alternative Services:** I understand that if I don't want to be treated by providers at Transitional Care Management, LLP, I can contact the Department and find out if there are other professionals who I can see instead. I understand that if I my treatment is terminated by the Department, that Transitional Care Management, LLP is no longer able to provide services, including medication management. Transitional Care Management, LLP will provide referral sources upon my request. Following Department guidelines, clients are advised to report to an Emergency Room or urgent care if they are experiencing acute medication withdrawal following termination of services.
12. **Hold Harmless:** I agree to hold Transitional Care Management, LLP harmless from any liabilities or damages which may arise pursuant to the services provided or communication with the Department.
13. **Revoke this Release:** I understand that if I want to revoke this release I can do so at any time by submitting a letter to Transitional Care Management, LLP indicating that I want to revoke this release.

Your signature below will indicate that you have read and understand the above. If you have any questions, please resolve those questions before you sign this form.

_____ _____

Client's Name/Signature Date

_____ _____

Staff Signature Date