ADULT CLIENT INTAKE

CLIENT INFORMATION

Name: _____

Preferred Name: _____

Gender: M ☐ F ☐ **Other:** _____

DOB: _____ **SSN#**: _____

Physical Address: _____

City: _____ **State**: ___ **Zip**: _____

Mailing Address (if different): _____

City: _____ **State:** ___ **Zip:** _____

Email: _____

Home#: _____ **Cell#:** _____

Work#: _____ **Other#:** _____

Is it ok to communicate via text? ☐Yes ☐No

May we leave a voicemail? ☐Yes ☐No

Marital Status:
☐Single ☐Married ☐Widowed ☐Divorced ☐Separated ☐Partnership

Gender Identity: ☐Male ☐Female ☐Transgender ☐Choose not to disclose ☐Other_____

Sexual Orientation: ☐ Heterosexual ☐Homosexual ☐Bisexual ☐Choose not to disclose ☐Other_____

Employment Status:
☐I am employed ☐I am unemployed ☐I am disabled ☐I am retired ☐I am a student

Employer: _____

Address: _____

City:_____ **State**:_____**Zip:** _____

Ethnic Background: ☐White ☐Black ☐Hispanic ☐American Indian ☐Asian Pacific Islander ☐Other _____

Religious/Spiritual Belief System (if any): _____

How did you hear about us?
☐Another Counseling or Mental Health Treatment Center
☐Internet Search
☐Referral from relative, friend or existing client
☐Brazos County/TDCJ/Attorney
☐Therapist, Psychiatrist, Physician or Hospital Staff
☐Other: _____

INSURANCE INFORMATION

☐ I choose **NOT** to use health insurance and will pay out of pocket for services provided by Brazos Valley Mental Health and Wellness.

☐ I **DO** have health insurance and would like Brazos Valley Mental Health and Wellness to send claims to my insurance company. I will provide a copy of my insurance card. I understand that I am responsible to pay deductible charges, co-insurance, and copays.

Insurance Co: _____ Member ID #: _____

Group #: _____ Relation to policyholder: **Self** **Spouse** **Child**

Policyholder: _____ DOB: _____

Address: _____

☐ A **THIRD PARTY** is responsible for paying for all professional services rendered to me by BVMHW.

Name of Business/Organization: _____ Phone # _____

Billing address: _____Contact: _____

☐ I was **REFERRED** for BIPP or Anger Management classes by Brazos County, TDCJ, CPS, or other organization.

Who is your Parole/Probation/Attorney/Case Worker? _____

Phone #: _____County: _____ Email: _____

Signature: _____

EMERGENCY CONTACT

Name:_____ Phone: _____

Relationship to client: _____

CREDIT CARD ON FILE AGREEMENT

Brazos Valley Mental Health and Wellness has now implemented a policy which enables you to maintain your credit card information securely on file. In providing us with your credit card information, you are giving Brazos Valley Mental Health and Wellness permission to automatically charge your credit card on file for your co-pay [or any other patient(s) you have listed on this form] at time of service, outstanding balance and any cancellation fees that may incur. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Co-pays/Coinsurance: Co-pays and coinsurance amounts are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, Brazos Valley Mental Health and Wellness will notify you via phone and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge can be provided upon request. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

I authorize Brazos Valley Mental Health and Wellness to charge co-pays and outstanding balances on my account to the following credit card: **(please circle one)**

Visa **MasterCard** **American Express** **Discover**

Credit Card Holder's Name: _____

Credit Card #: _____

Security #: _____ Expiration Date: _____

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below. If you choose to leave this card on file for other patients, please print names below:

Patient Full Name: _____DOB: _____

Patient Full Name: _____DOB: _____

CANCELLATION POLICY

If you fail to cancel a scheduled appointment without at least a 24-hour notice or fail to show up, you will be charged a $50 cancellation fee for your missed appointment.

This fee is charged unless the absence is due to illness or emergency. Your stored credit card on file will be used to collect the missed appointment fee.

Reminder calls, emails and texts are sent as a courtesy. It is ultimately your responsibility to maintain your appointment or notify us of any changes.

Brazos Valley Mental Health and Wellness reserves the right to discontinue treatment with a client has THREE no-show cancellations.

I have read and agree to the Brazos Valley Mental Health and Wellness Credit Card on File and Cancellation Policy terms.

_____ _____

Client/Parent or Guardian Signature Date

_____

Client/Parent or Guardian Printed Name

BRAZOS VALLEY
MENTAL HEALTH AND WELLNESS

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, AND ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Patient Date of Birth: _____

While providing services to you, we may create, receive, and store individually identifiable information, including information that relates to health care and payment for health care ("Personal Information"). It is often necessary to use and disclose this information to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a HIPAA Notice of Privacy Practice that describes these uses and disclosures. As described in our Notice of Privacy Practices, the use and disclosure of your Personal Information for treatment purposes not only includes care and services provided here, but also disclosures of your Personal Information as may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your Personal Information for purposes of payment may include, for example, the submission of this information to a billing agent for processing claims or obtaining payment and/or submission of claims to insurers.

When you sign this consent document, you expressly agree that we can and will use and disclose your Personal Information to treat you, to obtain payment for our services, and to operate Brazos Valley Mental Health and Wellness. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your information in accordance with this consent.

- ☐ **I HAVE READ THIS CONSENT AND UNDERSTAND IT. BY SIGNATURE, I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.**

- ☐ **I DO NOT CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.**

- ☐ **I ALSO ACKNOWLEDGE WITH SIGNATURE, THAT A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES HAS BEEN MADE AVAILABLE TO ME.**

Patient/Legal Representative Signature: _____ Date: _____

If you are signing as a legal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____ Print Name: _____

BRAZOS VALLEY
MENTAL HEALTH AND WELLNESS

Limits of Confidentiality

Contents of all therapy sessions are considered confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Notes exceptions are as follows:

- **DUTY to WARN and PROTECT**
  When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases which the client discloses or implies a plan for suicide, the healthcare professional is required to notify legal authorities and make reasonable attempts to notify the family of the client
- **ABUSE of CHILDREN and VULNERABLE ADULTS**
  If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child or a vulnerable adult is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or local authorities.
- **PRENATAL EXPOSURE to CONTROLLED SUBSTANCES**
  Mental health professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
- **MINORS/GUARDIANSHIP**
  Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.
- **AGENCY CONSULTATION**
  Our agency regularly engages in treatment consultation between therapists. By signing below, client gives permission for his/her case to be discussed amongst BVMHW therapists/staff in order to allow for additional treatment planning.
- **INSURANCE PROVIDERS** (when applicable)
  Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates and times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries.

I have read the above Limits of Confidentiality. I understand and agree to their meanings and ramifications.

_____ _____

Client/Parent or Legal Representative Signature Date

_____

Client/Parent or Legal Representative Printed Name

BRAZOS VALLEY
MENTAL HEALTH AND WELLNESS

Consent for Treatment

Psychotherapy is a working cooperative relationship between you and your therapist. Each member of this cooperative relationship has certain responsibilities. Your therapist will contribute their knowledge, expertise, and clinical skills. You, as the client, have the responsibility to bring an attitude of collaboration and a commitment to the therapeutic process. While there are no guarantees regarding the outcome of the treatment, your commitment may increase the likelihood of a satisfactory experience.

Fees and Appointments

1. Appointments are 60 minutes in length and will be based off the recommended treatment plan. If you are unable to keep an appointment, please cancel 24 hours prior to the appointment. If cancellation is not prior to 24 hours of the appointment time there will be a $50 cancellation fee. If you arrive 15 minutes after an appointment BVMHW staff reserves the right to cancel the session and charge a missed fee. After three cancelled appointments you may be discharged from the practice. Payment is expected at the time of service. We reserve the right to suspend therapy if services are rendered and not paid for after three sessions.
2. You are responsible for any copay, coinsurances, and or deductible payments based on your insurance policy. Please discuss any concerns regarding your insurance with the administrative staff, especially if your insurance policy changes in any way.
3. There is a minimum fee of $1,200 for court appearances; this fee may be adjusted on a case-by-case basis. Other non-session time fees may also be charged on a case-by-case basis.
4. There is a $30 service fee for any returned checks. If determined that therapy will continue, you must agree in writing to a payment plan to reduce overdue balance to zero, in addition to the regular session fees.

Confidentiality

1. Communication between you and your therapist is confidential. This means that your therapist will not discuss your case orally or in writing without your expressed written permission.
2. Your therapist has an ethical and legal obligation to break confidentiality under the following circumstances:
    a. If there is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect.
    b. If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit.
    c. If you disclose that you knowingly develop, duplicate, print, download, stream, or access through any electronic or digital media or exchanges, a film, photograph, video in which a child is engaged in an act of obscene sexual conduct.
    d. If <u>you</u> introduce your emotional condition into a legal proceeding.
    e. If there is a court order for release of your records

Therapist Availability and After-Hours Emergencies

Administration check for voice mail messages during normal business hours. Messages left outside of normal BVMHW hours of operation will be checked the next business day. If you have any emergency that needs immediate attention you may need to seek assistance at the nearest emergency service department.

Child Care

BVMHW does not provide childcare and is not responsible for children or adolescents left unsupervised in the waiting room. Minors must be accompanied by an adult; children under the age of 10 must be under supervision in the waiting room. If you must leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child.

Additional Rights and Responsibilities

In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason and without any obligation, except for payment of fees for services already provided. You have the right to question any aspect of your treatment with your therapist. You also have the right to expect that your therapist will maintain professional and ethical boundaries by not entering other personal, financial, or professional relationships with you.

BVMHW reserves the right to discontinue counseling at any time including, but not limited to, a violation by you of this Consent for Treatment, a change or reevaluation by BVMHW of your therapeutic needs, BVMHW's ability to address those needs, or other circumstances that led BVMHW to conclude in its sole and absolute discretion that your counseling needs would be better served with another BVMHW therapist or at an another counseling facility. Under such circumstances, BVMHW will suggest an appropriate therapist(s) or counseling agency.

Your signature below indicates that you have read and understand this information, may receive a copy of this consent form, give permission to BVMHW to provide counseling services, and that this contract is binding for all future sessions you may have with this entity.

Signature of Client/Parent/Legal Representative: _____ Date: _____

BRAZOS VALLEY
MENTAL HEALTH AND WELLNESS

CONSENT FOR RELEASE OF INFORMATION

Client Information

Name: _____ Maiden/Other Name: _____

Date of Birth: _____ Telephone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Health Information Release

☐ I authorize Brazos Valley Mental Health and Wellness to **RECEIVE** information **FROM:**
☐ I authorize Brazos Valley Mental Health and Wellness to **RELEASE** information **TO:**

Provider/Person/Organization Name _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Purpose of Disclosure

☐ Continuity of Care ☐ Client Request ☐ Legal/Attorney ☐ Parole/Probation
☐ Other – please explain: _____

Health Information to Release

☐ **Entire Health Record** (includes all records listed below)

☐ **Part of Health Record** (check one or more items)

- ☐ Mental Health Diagnostic Assessment
- ☐ Mental Health Progress Notes/Discharge Summary
- ☐ Chemical Health Rule 25 Assessment/Diagnosis/Summary
- ☐ Chemical Health Progress Notes/Discharge Summary
- ☐ Chemical Health Treatment Plan
- ☐ Chemical Health Collateral
- ☐ Mental Health Treatment Plan
- ☐ Psychological Evaluation
- ☐ Physical Health Records
- ☐ Completion Certificate
- ☐ Billing/Payment Records
- ☐ Other (please describe): _____

This authorization only covers the period from _____ to _____

Authorization

This authorization will expire no more than 12 months from the date I sign this form unless otherwise specifically permitted by law.
I understand that:

- I have the right to revoke this authorization IN WRITING at any time.
- A revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- Information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- That my treatment, payment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- Until payment has been made no information will be released.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print Name of Legal Representative Relationship to Client

Payment

☐ Cash: $_____

☐Check Number: _____

☐Debit/Credit Card:

Name on Card: _____

Card Number: _____

Date of Expiration: _____ CVC: _____

Staff Use ONLY

# of pages: _____ per cost: _____

Date Processed: _____

BRAZOS VALLEY
MENTAL HEALTH AND WELLNESS

Adult Initial Evaluation

_____
Date

_____ _____
Patient's Name Date of Birth

Gender Identity:

Male / Female / Transgender / Choose not to disclose / Other

Sexual Orientation:

Straight / Homosexual / Bisexual / Choose not to disclose / Other

Ethnic background:

White / Black / Hispanic / American Indian, Alaskan Native / Asian Pacific Islander / Other

Religious/Spiritual belief system (if any): _____

Briefly describe the events that led you here today: _____

_____

_____

Have you seen a doctor, counselor/therapist for this issue in the past? **Y N** If yes, please list names and approximate dates of treatments and/or hospitalizations.

_____

_____

Do you have (or had) any medical issues: **Y N** If yes, circle all that apply

High Blood Pressure Diabetes Thyroid Heart Lungs Kidneys

Stomach Seizures Headaches Other: _____

Do you have any developmental/intellectual disabilities? **Y N** If yes, please describe: _____

_____

Who is your Primary Care Doctor? _____

When was your most recent physical/bloodwork? _____

Have you ever had an EEG, CT, MRI of the head? **Y N** If yes, were there abnormal findings? **Y N**

Allergies: _____

All current medications:_____

_____

_____

Describe any relevant stress: _____

_____

_____

Describe your current employment and financial situation: _____

_____

_____

Describe any relevant legal issues: _____

_____

_____

Use the table below to describe your **current living situation**:

Name	Relation to self	Age	Education/Occupation	How would you describe this person?	Mental health, alcohol or drug problem?

Use the table below to describe your **family of origin/family you grew up with**:

Name	Relation to self	Age	Education/Occupation	How would you describe this person?	Mental health, alcohol or drug problem?

Who do you consider your support system? (example: friends, teachers, neighbors, etc.) _____

_____

Have you been a *victim* of abuse? **Y N** What kind? **Emotional Sexual Physical**

Have you been an *offender* of abuse? **Y N** What kind? **Emotional Sexual Physical**

Have you ever experienced significant trauma? **Y N** If yes, please describe: _____

_____

_____

_____

Have you ever been suicidal or caused harm to yourself? **Y N** If yes, please describe when/why/how:

_____

_____

_____

Please circle any of the following symptoms or complaints that apply to your situation

sad mood

low energy

hopelessness

worthlessness

crying spells

guilt

irritability

decreased motivation

loss of interest in usual activities

hyperactivity

impulsiveness

elevated mood

racing thoughts

hallucinations

delusions

disorganized speech

concentration/memory difficulties

increased sexual interest

decreased sexual interest

decreased appetite

difficulty falling asleep

early morning awakening

difficulty staying asleep

excessive sleeping

suicidal thoughts

thoughts of harming others

anxious/worried

panic attacks

fear of leaving the house

fear of embarrassing oneself in public

intruding, uncomfortable, upsetting thoughts

repetitive thoughts or behavior

excessively orderly or perfectionism

periods of "lost" time

excessive anger or aggressiveness

difficulty trusting others

binging/purging

self-harm (cutting, burning)

paranoia

uncontrollable moving

confusion

changes in eating habits

inability to cope

Have you **ever** used illegal substances and/or alcohol? **Y N** If yes, complete the table below:

Substance	Age at first use	Used in last 30 days?	Average Quantity Used	Last Used	Amount Used
Alcohol					
Sedatives/Barbiturates					
Heroin/Opioids					
Cocaine					
Other Stimulants					
Marijuana					
Hallucinogens					

In the past two years, has there any episodes of memory loss due to substance abuse? **Y N**

Have you had any personality changes due to the use of substances? **Y N** If yes, describe:

_____

In the past 5 years, have you had any legal issues (arrests, incarceration) related to your substance/alcohol use? **Y N** If yes, describe: _____

_____

Does someone think you have a serious substance use problem? **Y N** If yes, Who? _____

_____

In the past year, has there been an out-of-control experience due to substance use? **Y N** If yes, describe:

_____

_____

_____

Do you have a history of serious problems with the use of substances? **Y N** If yes, describe:

_____

_____

_____

Do you have a history of substance abuse treatment (including 12-step programs)? **Y N** If yes, when, where and for how long? _____

_____

_____

What are your strengths? _____

_____

_____

Do you have limitations? **Y** **N** If yes, describe: _____

_____

_____

Is there anything else you'd like your therapist to know? _____

_____

_____

_____

_____

_____

_____

By signing below, I certify all information is true and correct to the best of my knowledge.

_____ _____

Patient/Parent or Guardian Signature Date

_____

Patient/Parent or Guardian Name (Print)

BRAZOS VALLEY
MENTAL HEALTH AND WELLNESS

Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal therapist who will see you on an on-going, regular basis.
- Competent, considerate, and respectful health care, regardless of race, creed, age, sex, or sexual orientation.
- A second medical opinion from the therapist of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment, and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency.
- Be free from mental, physical, and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plans.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment, or service or to select a different therapist.

You are responsible for:

- Knowing your health care therapist's name and title.
- Giving your therapist correct and complete health history information, e.g. allergies, past and present illnesses, medications, and hospitalizations.
- Providing staff with correct and complete name, address, telephone, and emergency contact information each time you see your therapist so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your therapist.
- Signing a "Release of Information" form when asked so your therapist can get medical records from other therapists involved in your care.
- Telling your therapist about all prescription medication(s), alternative, i.e. herbal, or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your therapist about any changes in your condition or reactions to medications or treatment.
- Asking your therapist questions when you do not understand your illness, treatment plan or medication instructions.
- Following your therapist's advice. If you refuse treatment or refuse to follow instructions given by your health care therapist, you are responsible for any medical consequences.
- Keeping your appointments and arriving within 15 minutes of scheduled appointment time. If you must cancel your appointment, please contact BVMHW 24 hours prior to the appointment time.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

- **Request Confidential Communications.** Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing information to a different address, or by using email for your personal email address. We will accommodate these requests if they are reasonable. If you want to ask for confidential communication, send a written request to BVMH at the address or fax shown on this notice.
- **Access.** Ask to see or to get photocopies of your medical files. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay a reasonable, cost-based fee for photocopies in advance. If we deny your request, we will send you a written explanation, and instruction about how to get an impartial review of our denial if one is legally required. If you want to review or get photocopies of your medical information, send a written request BVMH at the address or fax shown at the beginning of this notice.
- **Amendment**. Ask us to amend your medical information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. If we do not agree, you can write a statement of your position, and we will include it with your confidential information along with any rebuttal statement that we may write. If you want to ask us to amend your medical information, send a written request, including your reasons for the amendment, to BVMH at the address or fax shown on this notice.
- **Accounting**. Get a list of the disclosures that we have made of your medical information within the past six years (or a shorter period if you want), except disclosures for purposes of treatment, payment, or health care operations, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay a reasonable, cost-based fee for them in advance. If you want to ask us for an accounting, send a written request to BVMH at the address or fax shown on this notice.
- **Copy of the Notice of Privacy Practices**. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. To request a copy, send a written notice to the BVMH at the address or fax shown on this notice.

CHANGES TO OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this Notice, the new privacy practices will apply to your medical information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

You can complain if you feel we have violated your rights.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877- 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to BVMH the address or fax shown on this Notice. If you prefer, you can discuss your complaint in person or by phone.

CONTACT PRIVACY OFFICIAL

Our Privacy Official is Michelle D. Chmelar, RHIT michelle@bvmhw.com and phone number is (979) 777-1683.

EFFECTIVE DATE

This Notice is effective as of October 7, 2020.

BRAZOS VALLEY
MENTAL HEALTH AND WELLNESS

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

117 E. Royal Street
Bryan, TX 77845
Phone (979) 595-4415
Fax (979) 985-2127
www.brazosvalleymentalhealth.com

GENERAL RULES

We take our legal responsibilities seriously, and care about your privacy. We are obligated by law to give you this Notice of Privacy Practices. It explains our privacy practices with respect to your medical information, which includes mental health information, billing information, demographic information, and other individually identifiable health information.

TYPICAL USES AND DISCLOSURES

We typically use or share your health information in the following ways:

- **To treat you ("*treatment*")**

We can use your health information and share it with other professionals who are treating you.
Examples: *We use this information to set up an appointment with you, and to communicate with your other health care providers. If we refer you to another doctor or clinic, we may also share your information in that case.*

- **To run our organization ("*health care operations*")**

We can use and share your health information to run our center, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

- **To bill for your services ("*payment*")**

We can use and share your health information to bill and get payment from you, health plans, or other entities.
Example: *We may give information about you to your health insurance plan so it will pay for your services.*

AUTHORIZATION REQUIRED

We will not use your private health information for purposes that are not allowed by the federal or state laws without your written authorization. Specifically, the following uses and disclosures of your information will require an authorization:

- Disclosure of psychotherapy notes
- Disclosure for marketing purposes
- Disclosure that would constitute as a sale of PHI

Other uses and disclosures will not be made unless an authorization has been provided. Authorizations may be revoked at any time by written revocation.

NOTIFICATIONS

We may use your information to call and remind you of scheduled appointments. We may also contact you for check ins and other situational options regarding your treatment.

OTHER USES AND DISCLOSURES

We are allowed, or sometimes required, to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues**

We can share health information about you for certain situations, such as:

  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's
  - Health or safety

- **Do research**

We can use or share your information for health research

- **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services, if it wants to see that we are complying with federal privacy law.

- **Address workers' compensation, law enforcement, and other government requests**
  - We can use or share health information about you: For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
  - Respond to lawsuits and legal actions
  - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

SPECIAL RESTRICTIONS ON USES AND DISCLOSURES

Unless you give us written permission, we will not use or disclose your medical information in these cases:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Fundraising. In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have com promised the privacy or security of your information. We must follow the duties and privacy practices described in this Notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

The law gives you many rights regarding your mental health information however you can request a restriction. Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment) and payment of confidential care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. If you pay for a service out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will accommodate this request unless a law requires us to share that information. To ask for a restriction, send a written request to BVMH at the address or fax shown on this notice.