**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 you 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: ________