MINORS IN MENTAL HEALTH THERAPY

1. The parent/ Legal Guardian whose signature is on the Financial Agreement is ultimately responsible for prompt payment on the account. This applies no matter which parent schedules the appointment, brings the child, or incurs late cancelation charges. It is important that the parent who signed the Financial Agreement fully informs the other parent as to our financial policies to avoid confusion. This is especially important when the parents are divorced and not living together. Whoever signs the Financial Agreement is responsible for any and all billable charges on the child's account. Disputes on who scheduled the child's appointment or requested the services are to be resolved between the parents and not with our office.
2. In order for children to participate and speak freely in therapy they need to be assured of their rights to confidentiality. The child needs to know what information will be kept between the child and therapist and what information will be shared with parents and other parties.
3. When a child makes a comment or shows other signs that indicate a suicide risk may be present a parent is informed immediately.
4. When a child indicates that they are intending to physically harm another person the parents and the other person are promptly notified.
5. When a child makes a comment, or shows signs, that physical or sexual abuse may have taken place, both parents and Child Protective Services (TX) are notified. Physical/sexual abuse suspicions must be reported to Texas Child Protective Services as stipulated by Texas State Law.
6. Parents are always informed of progress in therapy. The child's primary relationship is with parent(s). The main purpose of mental health therapy with a child is to enhance and improve the child's life outside of the therapy session.
7. Non-custodial parents will be notified of their child(ren)'s participation in therapy. Non-custodial parents will be required to sign this form indicating that both parents of the child are aware of and are in agreement with the child(ren) entering mental health therapy.

By signing this form, you as the parent are indicating that you understand the therapy information that will be kept confidential and the information that would be promptly shared with you. By signing you are also giving the assigned therapist your permission to provide mental health counseling to you child.

Name of Child(ren) : ____________________

Parent/Legal Guardian X ____________________

Print Name and Date ____________________

Parent/Legal Guardian X ____________________

Print Name and Date ____________________

Assigned Therapist: ____________________

MINOR CHILD INTAKE

CLIENT INFORMATION

Minor's Name:___________________________________

Preferred Name: _________________________________

Gender: M ☐ F ☐ **Other:** _____________________

DOB: ______________ **SSN#**: ____________________

Address:_______________________________________

City:__________________ **State**:___ **Zip**:___________

Email: ____

City:__________________ **State**:___ **Zip**:___________

Home#:_________________**Cell#:** ________________

Work#:______________**Other#:**__________________

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

May we leave a voicemail? ☐Yes ☐No

School Attending:_________________________________

Grade:____

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

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

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

☐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** to us for BIPP or Anger Management classes by Brazos County, TDCJ or CPS.

Who is your Parole/Probation/Case worker? ____

Phone #: _________________County: _______________ Email: ____

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

**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: ________

MINOR CHILD PERSONAL HISTORY

Date ______/______/______

Child's Name ____ Child's Date of Birth ______/______/______

PRIMARY REASON(S) FOR SEEKING SERVICES

Please indicate the primary reason(s) you are seeking services for your child:

☐ Anger	☐ Eating Disorder	☐ Traumatic Events
☐ Anxiety	☐ Sleeping Problems	☐ Abuse Victim
☐ Depression	☐ Fear/Phobias	☐ Addictive Behaviors
☐ Grief/Loss	☐ Sexual Concerns	☐ Behavioral Concerns
☐ Violent Outbursts	☐ Alcohol/Drug Use	☐ Other: __________________________________

How long have the behaviors you are concerned with been present?

☐ 0-3 months ☐ 3-6 months ☐ 6 months – 1 year ☐ 1 year or more

List any additional outside stressors or challenges that are influencing your child's behavior: __________________

____

____

Describe the onset of your child's current symptoms: ____

____

Has this issue been treated by other means before now? ☐Yes ☐ No If yes, describe what was done and Your child's response to the intervention:____

____

____

PSYCHOSOCIAL HISTORY

List all current members of your household and their relationship to your child

name ____ relation ____________________________________

name ____ relation ____________________________________

name ____ relation ____________________________________

name ____ relation ____________________________________

Does your child get along with all members of your household? ☐Yes ☐ No If no, describe why: _____________

____

____

Describe your family's conflict resolution and decision-making processes

Conflict Resolution ____

Decision-making ____

Describe your home rules, expectations, and chores

Rules ____

Expectations ____

Chores ____

Has your child experienced any significant separation from parents or other family members? ☐Yes ☐ No

If yes, which family members and for how long? ____

____

____

Has your child ever been placed in foster care? ☐Yes ☐ No If yes, at what age and for how long? _________

____

Does your family regularly attend church or participate in other spiritual support systems? ☐Yes ☐ No

If yes, describe: ____

____

Any historical or current legal involvement? ☐Yes ☐ No If yes, describe: ___________________________

____

____

Other relevant information ____

____

____

CHILDCARE AND SCHOOL HISTORY

List ages and types of childcare provided for your child: Home w/parent/relative ___________________________

Daycare ____ School ____

Home w/other caregiver ____________________________ Other ____

What grade is your child currently in? ____________ Does your child maintain good grades? ☐Yes ☐ No

If no, describe: ____

Does your child have IEP or Special Education services? ☐Yes ☐ No

Describe your child's strengths and challenges as they relate to childcare or school:

Strengths ____

Challenges ____

Describe your child's relationships as they apply to

Peers ____

Teachers ____

Childcare providers ____

Does your child have any issues with school attendance? ☐Yes ☐ No ☐ NA

If yes, describe why: ____

Does your child maintain a group of friends? ☐Yes ☐ No

Has your child been a victim of bullying? ☐Yes ☐ No

Other relevant information ____

____

____

____

SOCIAL AND BEHAVIORAL HISTORY AND CURRENT STATUS OF CHILD

Describe your child's current temperament ____

____

Does your child react well to frustrating or difficult tasks? ☐Yes ☐ No

If no, describe: ____

Has your child experienced significant losses (i.e., separation from parents, illness, death)? ☐Yes ☐ No

If yes, describe: ____

Has your child been exposed to any of the following types of abuse?

Physical abuse ☐Yes ☐ No Sexual abuse ☐Yes ☐ No

Emotional abuse ☐Yes ☐ No Exposure to violence ☐Yes ☐ No

If yes, describe: ____

____

Has your child experienced any of the following traumatic events?

Accidents ☐Yes ☐ No Family member/pet loss ☐Yes ☐ No

Witness to domestic violence ☐Yes ☐ No Police/CPS involvement ☐Yes ☐ No

If yes, describe: ____

____

In your child's life, have they ever had any experience that was so frightening, horrible, or upsetting that in the past month they:

- had nightmares about it or thought about it when they did not want to? ☐Yes ☐ No
- tried hard not to think about it or went out of their way to avoid situations that reminded them of it? ☐Yes ☐ No
- were constantly on guard, watchful, or easily startled? ☐Yes ☐ No
- felt numb or detached from others, activities, or their surroundings? ☐Yes ☐ No

Does your child regularly use social media? ☐Yes ☐ No

Other relevant information ____

____

____

DEVELOPMENTAL HISTORY TO AGE 5:

Indicate all factors that influenced your child's developmental growth to age five (5)

☐ Unwanted Pregnancy	☐ Complicated pregnancy/delivery
☐ Alcohol or drug exposure under age 5	☐ Colic
☐ Toilet training/bathing issues	☐ Frequent childhood illness
☐ Irregular sleep schedule	☐ Inadequate nutrition
☐ Walk/crawl/speech delays	☐ Extended isolation
☐ Difficulties with weight loss/gain	☐ Childhood eating disorders
☐ Parent incarceration	☐ Suicidal thoughts/attempts in family
☐ Separation anxiety	☐ Frequent temper tantrums
☐ Parent divorce	☐ Multiple moves/relocations
☐ Night terrors	☐ Constant family stress
☐ Parent with physical illness	☐ Food allergies
☐ Marital discord in home	☐ Appetite/feeding difficulties
☐ Limited socialization	☐ Substance use during pregnancy
☐ Attention span difficulties	

List all members in the home during this time (ages 0-5) and their relation to your child

name ____ relation ______________________________________

name ____ relation ______________________________________

name ____ relation ______________________________________

name ____ relation ______________________________________

Were there any issues or concerns with your child's pre-school readiness screening? ☐ Yes ☐ No

If yes, describe: ____

Other relevant information ____

____

____

MEDICAL HISTORY AND CURRENT MEDICAL STATUS

Describe your child's general health ☐ Excellent ☐ Good ☐ Average ☐ Poor

When was your child's last checkup? ____

Does your child have any acute or chronic health problems? ☐Yes ☐ No If yes, describe: _______

____

Has your child ever been hospitalized? ☐Yes ☐ No For how long __________________________

Reason for hospitalization ____

Does your child maintain a healthy appetite? ☐Yes ☐ No If no, describe: ______________________

____

Does your child maintain a healthy sleep pattern? ☐Yes ☐ No If no, describe: _________________

____

Has your child ever been on or currently taking any medications? ☐Yes ☐ No

Medication ____ Currently taking? ☐Yes ☐ No

Medication ____ Currently taking? ☐Yes ☐ No

Medication ____ Currently taking? ☐Yes ☐ No

Medication ____ Currently taking? ☐Yes ☐ No

Does anyone in your family have current or historical mental illness? ☐Yes ☐ No

Family member ___________________________ Mental Illness _______________________________________

Family member ___________________________ Mental Illness _______________________________________

CHEMICAL USE HISTORY

Does your child have any current/historical substance or alcohol use? ☐Yes ☐ No If Yes:

- Have you ever felt your child ought to cut down on their alcohol or substance use? ☐Yes ☐ No
- Has your child ever been annoyed by being criticized for alcohol or substance use? ☐Yes ☐ No
- Has your child felt bad or guilty about alcohol or substance use? ☐Yes ☐ No
- Has your child ever felt the need to use alcohol or substances right away in the morning? ☐Yes ☐ No
- Does your child smoke, vape, or chew? ☐Yes ☐ No
- Does your child use pain medication? ☐Yes ☐ No

Please indicate below which substances you have used (if any): ☐ Never used any substance

☐Alcohol ______Age of first use ______# of days used in the last 30 days ______Amount Used
☐ Marijuana ______Age of first use ______# of days used in the last 30 days ______Amount Used
☐ Cocaine/crack ______Age of first use ______# of days used in the last 30 days ______Amount Used
☐ Meth/Amphetamine ______Age of first use ______# of days used in the last 30 days ______Amount Used
☐ Heroin ______Age of first use ______# of days used in the last 30 days ______Amount Used
☐ Other opiates ______Age of first use ______# of days used in the last 30 days ______Amount Used
☐ Synthetics ______Age of first use ______# of days used in the last 30 days ______Amount Used
☐ Inhalants ______Age of first use ______# of days used in the last 30 days ______Amount Used
☐ Benzos ______Age of first use ______# of days used in the last 30 days ______Amount Used
☐ Hallucinogens ______Age of first use ______# of days used in the last 30 days ______Amount Used
☐ Over the counter ______Age of first use ______# of days used in the last 30 days ______Amount Used
☐ Other:_________ ______Age of first use ______# of days used in the last 30 days ______Amount Used
☐ Nicotine ______Age of first use ______# of days used in the last 30 days ______Amount Used

Does anyone in the family have current/historical substance or alcohol use? ☐Yes ☐ No

Family member _____________________________ Substance or Alcohol Use _______________________________

Family member _____________________________ Substance or Alcohol Use _______________________________

Other relevant information ____

____

____

____

____

____

____

____

Does anyone in the family have current/historical substance or alcohol use? ☐Yes ☐ No

Family member _____________________________ Substance or Alcohol Use _______________________________

Family member _____________________________ Substance or Alcohol Use _______________________________

Other relevant information ____

____

____

____

____

____

____

____

117 East Royal Street, Bryan, TX. 77801
979-777-1683
info@bvmhw.com
www.brazosvalleymentalhealth.com

Policy for Working with Child of Separated/Divorced Parents

When the therapist is working with a child with separated or divorced parents, the counseling process can face many challenges. As a result, the therapist adheres to this policy to guide the counseling process to ensure that the best interests of the child are addressed in the counseling process.

Therapist's Beliefs

- The best treatment for children is for the child to be viewed within the context of their family and to involve all active and engaged caregivers to create the most significant change.

- Even though the parents have decided that separating is the right choice for them, the child does not share this view. All children will benefit from an ongoing relationship with both parents, unless serious parental deficits and/or abuse and/or neglect are occurring which could significantly impact the health (physical and mental) and safety of the child.

- A child in counseling will experience the best outcomes if he or she believes that the therapist can be trusted to explore thoughts, feelings and opinions. If the expectation is that the therapist reveals the content of the session to the parent(s), the child can and will shut down and will gain no benefit from the counseling process.

- The goal of the therapist is to help the child to cope with the challenges that their parents' separation or divorce has caused them and to develop skills to overcome those challenges. It is also the goal of the therapist to help the parents and family in any way that is appropriate to help the child to achieve these skills. **It is not the goal of the therapist to pick sides or identify one parent as the right or best parent. It is also not the goal of the therapist to lecture one parent into complying with the demands of the other parent.** This approach is counterproductive and not helpful to the child.

- The involvement of court hearings and proceedings is counterproductive to the goals of the counseling relationship and the therapist hopes that parents involved in their child's counseling will take a step back from court proceedings regarding custody and recommendations for the child until the counseling experience has been completed. This does not include court proceedings related to child abuse and/or neglect.

Policy for Working with Children of Divorced/Separated Parents

Legal/Custody

- The therapist will require a copy of court documentation indicating custody arrangements, allowances or restrictions for contact between parent and minor child,

court orders for counseling or any other legal documentation related to the medical care of the child before any counseling will take place.

- The therapist will try to include both parents in the counseling process except for in cases when it is expected that doing so would cause serious detriment to the child.

Confidentiality

- Parents should understand that **ALL** verbal and written communication (face-to-face, phone call, email, written communication, or any other documentation provided to the therapist) is allowed to be shared with the other parent and with the child if the therapist deems it necessary. Any written communication will become part of the child's clinical file as record of communication.

    - It is unethical for the therapist to keep secrets regarding threats of bringing the other parent back to court, allegations of the other parent being the "cause" of the child's problems, threats to sabotage the parent's relationship with the child, etc. Aside from suspected abuse and neglect, **the therapist cannot and will not keep these secrets in order to create the most healthy and productive working relationship.**

- The law indicates that parents have the right to access records of their child's treatment, however, parents should understand the difference between mental health records and medical records and the sensitive information contained within them. Mental health professionals have the right to refuse release of these records to parents or any other entity if they believe that doing so would cause harm to the child. In cases of separation and/or divorce, this is almost always the case as information shared within these records can never be un-read by the parents and can and will impact the parent-child relationship going forward. Therefore, the therapist will not release the mental health record of the child to the parent when it is not in the child's best interests to do so, unless required by law. The therapist urges the parents to respect this policy as it is in place to protect the wellbeing of the child as well as the quality of the parent-child relationship.

- The therapist welcomes the involvement of extended family and/or step-family as necessary and appropriate for the course of treatment. However, in order for the therapist to communicate with other family members besides the biological family (biological parents and siblings), both parents must sign releases of information allowing that communication. Communication with extended family and/or step-family will not be allowed unless both parents' consent to that communication. Depending upon the age of the child, the child's consent may also be required.

Communication

- The therapist will not be responsible for routine communication outside of the session with any parent who chooses not to attend the appointments. For example, the therapist cannot and will not contact the non-attending parent via phone or email after each session. It is simply not realistic to expect that the therapist will provide a summary letter, email or phone call to parents who choose not to come to sessions. If this is something that is required of your situation, then payment arrangements must be made in advance to account for this time. Health insurance will not cover email, letter or phone conversations. The expectation is that parents will communicate with each other regarding the child's treatment and recommendations. In most cases, for the therapist to arrange for additional communication outside of the session would only be encouraging an unhealthy coparenting relationship.

- The therapist will not accept phone calls, voice mails, emails or other communications directed at pitting the therapist against the other parent. If/when these communications are received, the other parent will be notified. Permitted communications include, but are not limited to:
    - Text messages/printed text message transcripts
    - Emails
    - Facebook messages, posts
    - Video and/or tape recordings
    - Voice mails
    - Other communication aimed at proving the other parent's wrong doing and encouraging the therapist to pick a side

- It is the therapist's duty to understand the history of the child and their family and what has contributed to the reason for counseling. This should not be misconstrued to mean that the therapist should be required to read or listen to any information that the parent(s) deem appropriate to share. The therapist reserves the right to dictate what information is appropriate and inappropriate for the counseling relationship and to refuse to accept information that isn't appropriate for the counseling relationship. Unless required by law, the therapist also reserves the right to ignore and/or not respond to any communication that is not appropriate for the counseling relationship, including but not limited to:
    - Emails used for the purpose of counseling
    - Requests for reviewing court documents
    - Journals/written records of behaviors
    - Phone calls of inappropriate content
    - Text messages between parent/parents and others
    - Email correspondence between the parent/parents and others
    - Facebook messages, posts
    - Video, pictures and/or tape recordings of the other parent
    - Voice mails

Financial

- The parent who initially sets up counseling for the child is considered the guarantor. This means that this parent is considered financially responsible for covering the cost of services and communicating cost and reimbursement with the other parent.
    - **It is the responsibility of the parents to provide the appropriate payments to the therapist, not the responsibility of the therapist to provide billing according to court ordered co-parenting financial agreements**. It is not feasible to expect the therapist to send separate, divided bills to each parent according to their agreed-upon percentage rates.
    - When requested, the therapist will provide receipt of payment to the parent(s) for their payments. It is the parents' responsibility to work together to share receipts, not the therapist's responsibility to update parents on what the other has and has not paid.

Scheduling

- The therapist expects parents to communicate regarding scheduled appointments. **The therapist will not be responsible for scheduling sessions according to non-custodial parent's visit schedule. It is not feasible to expect the therapist to remember the visit schedule and any changes to that schedule for each and every one of the children on their caseload.** The therapist expects that the parent scheduling the session will show respect to the needs of the child to spend time with both parents and will refrain from specifically, scheduling appointments as a way to take time away from the other parent.

Legal Proceedings

- In some cases, one or both parents may decide to take legal action regarding custody of the child. Therapy and legal testimony are very different services and the therapist's goal first and foremost is to create a supportive, safe relationship with the child for the purpose of achieving therapy goals. The therapist cannot and will not provide a recommendation regarding custody of the child when acting as the therapist for the child and family. The therapist will communicate with legal professionals as required by law, but all professionals and parents should know that the therapist's responsibility is for confidentiality and protection of the counseling relationship, not to assist one parent in "winning" their case.

- The therapist cannot speak to one parent's attorney without the consent of the other parent. In most cases, this is not a productive idea and the therapist recommends that there not be any communication between the therapist and attorney(s). When required by law, the therapist will communicate with legal professionals.

By signing below, you agree to the following:

- I have read the statements above and agree to comply with the policies listed in this document.

- I understand that if I break any of the rules listed in this document, I may be asked to discontinue the counseling relationship.

____ _________________________

Parent/Guardian Signature Date

____ _________________________

Parent/Guardian Signature Date

____ _________________________

Therapist Signature Date

- **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.

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.

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.