Behavioral Health Services

Alcohol and Substance Abuse Program

CLIENT NAME:_____

1. ASSIGNMENT OF BENEFITS: I request payment of private insurance and/or government benefits for my treatment be made to Wilson Counseling, LLC.

_____ _____
Signature of Client/Guardian Date

2. PRACTICE POLICIES AGREEMENT: I have been provided a copy of and read the Notice of Practice Policies and agree to the terms therein.

_____ _____
Signature of Client/Guardian Date

3. PERMISSION TO TREAT FOR MYSELF: I understand that I will be taking part in mental health services which are psychological in nature. I hereby give permission for Wilson Counseling to provide services.

_____ _____
Signature of Clieent/Guardian Date

4. PERMISSION TO TREAT FOR MY CHILD: I understand that I will be taking part in mental health services which are psychological in nature. I hereby give permission for Wilson Counseling to provide services. I understand that consent from both custodial parents is required for treatment services to be provided. I understand that both custodial parents will be provided opportunity to participate in treatment planning and, when appropriate and recommended by the treating clinician, participate in therapy sessions. I understand that the child is the identified client and billing will be made through insurance coverage on that child for client and/or family sessions. I understand that the decision to meet with me, my attorney, any other party or other attorney in any custodial or divorce proceeding is at sole discretion of the clinician.

_____ By initialing here, I affirm that I have sole custody of my child.

_____ _____
Signature of Parent 1 Date

_____ _____
Signature of Parent 2 Date

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5. <u>CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION.</u> When we evaluate, diagnose, treat and/or refer you or the person you represent, we will be collecting what the law calls Protected Health Information (PHI) about you. We need the information to decide what treatment is best for you and to provide that treatment. The Notice of Privacy Practices (NPP) that was given to you explains in more detail your rights and how we can use and share your information as regulated by the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information. We may share your PHI with others who provide treatment to you, who need it to arrange payment for your treatment, or for administrative purposes. In other situations, we can release information about your treatment only if you sign a written authorization form. Please read the Notice of Privacy Practices carefully. If you have a concern about the use of your information, you have the right to ask use to restrict how we use or share your information for treatment, payment or administrative purposes. You will have to tell use in writing what you want. Although we will try to respect your wished, we are not required to agree to the limitations you request. After you have signed this consent, you have the right to revoke it in writing and we will comply with your wishes about using or sharing your information from that time on, but we may have already used or shared some of your information which cannot be changed after the fact. By signing below, you are affirming that you have received a copy of our NPP, read our NPP and you are consenting to let us use your information here and send it to others as needed for your treatment.

_____ _____

Signature of Client/Guardian Date

8. <u>CLIENT TEXTING/EMAIL CONSENT.</u> The transmission of client information by email and/or texting has several risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks: 1) Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients. 2) Email and text senders can easily misaddress an email or text and send the information to an undesired recipient. 3) Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy. 4) Employers and on-line services have a right to inspect emails sent through their company systems. 5) Emails and texts can be intercepted, altered, forwarded or used without authorization or detection. 6) Email and texts can be used as evidence in court. 7) Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party. Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Therapist is not liable for breaches caused by third party. Email and texting are not appropriate for urgent or emergency situations. Provider cannot guarantee that any email and/or text will be read and responded to within any particular period of time.

_____ _____

Signature of Client/Guardian Date