Behavior Health Partners PLC

Client name: _____ Birthdate: _____

Legal Guardian: _____

CONSENT

- ✓ My consent for treatment/assessment of my child/myself, listed above is **voluntary**.
- ✓ I understand that no guarantees have been made to me about the results of this treatment/assessment; I understand the plan for this treatment/assessment and also understand the potential **risks and benefits**.
- ✓ I understand that it is **my responsibility** to inform my child's/my therapist if there are any significant changes in my child's/my physical or emotional condition.
- ✓ I understand that I have the **right to terminate** treatment/assessment with our/my therapist at any time I choose.
- ✓ I understand that if my child/I state or suggest that he/she is, or I am, abusing or have recently abused a child or vulnerable (incompetent, mentally disabled or otherwise restricted) adult, or a child or vulnerable adult is in danger of abuse, professionals at Behavior Health Partners, as health care professionals are, by law, **required to report** this information to the appropriate social services and/or legal authorities.
- ✓ I understand that if my child or I disclose intentions or a plan to harm another person and has/have the ability to carry out that plan, professionals at Behavior Health Partners have a **duty to warn** the intended victim and report this information to legal authorities. If my child/I clearly indicate(s) plans to harm himself/herself/myself, professionals at Behavior Health Partners are required to notify appropriate authorities or family members.
- ✓ For the purpose of payment for services, I give professionals at Behavior Health Partners **permission to disclose my information to any provider/organization/insurance carrier** that may be responsible under a contract to me for payment of incurred charges. Because some insurance companies or their representatives require reviews to assess the quality of the services for which they pay, I authorize professionals at Behavior Health Partners to release or share only that information which is necessary to complete the reviews, which could include information about my care, communicable diseases/infections, alcohol and drug abuse treatment, and other medical information. The undersigned authorizes professionals at Behavior Health Partners to release information contained in my child's/my medical records to insurance company(s), Medicaid, Medicare, or other third-party payers or their authorized representatives.

- ✓ I understand that, currently, **all therapists employed with Behavior Health Partners work part-time in their practice here**, and so are not always able to answer calls as they come in. When I leave a message, my therapist will do his/her best to return my call within 24 hours. In addition, if I have an emergency situation, I will call my physician or present at a hospital for emergency medical attention.

Confidentiality:

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.
8. When necessary for a supervising psychologist within our practice to review treatment plans and ongoing progress.

Regarding payment for service:

- ♦ I understand that I, the undersigned, am responsible for payment of all charges due and owing to Behavior Health Partners. I assign benefits payable directly to Behavior Health Partners.

- ♦ I authorize Behavior Health Partners and their billing service to directly bill any third-party payer which may provide coverage to my child/me, and request that any payments are made directly to Behavior Health Partners. The undersigned assigns to Behavior Health Partners all rights to benefits, insurance proceeds, settlement payments or judgments to which my child/I may be entitled for the services rendered by professionals employed by Behavior Health Partners during the entire continuum of care rendered.

- ♦ I understand that I may review charges to my account at any time and that I may be charged up to the full rate if proper 24-hour notice is not given for broken appointments. I hereby acknowledge that I have received information regarding issues related to broken appointments.

- ♦ I understand that if I do not assure payment in a timely manner, my outstanding bill may be turned over to a collection agency or legal counsel for collections.

- ♦ I understand that this Consent contains all the terms of the agreement between the parties with respect to its subject matter and may be emended only in writing by both parties. This Consent shall be binding upon the parties hereto, their heirs, executors, administrators or authorized representatives of Behavior Health Partners.

Additional:

- I understand that by signing below, I am indicating that I have the authority (e.g. Legal guardianship, Full or Partial legal custody) to provide consent for the child who will be the client of Behavior Health Partners.

_____	_____
Client/Parent/Legal Guardian Signature	Date
_____	_____
Guarantor Signature	Date
_____	_____
Witness	Date