**Clinical Intake Paperwork**

** Copy of insurance card is included front and back**

** Copy of State ID/ Driver License is included**

** Copy of CC is included front and back**

**Primary Insured Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Emergency Contact same as above:

**Biopsychosocial Assessment**

**What brings you to therapy?**

**What are the main goals for therapy?**

**Current Symptoms:**

**What symptoms have you had now or within the past 30 days? Select all that apply**

口Angry 口 Hearing things 口 Recurring Nightmares

口 Addiction 口 Hopeless 口 Relationship Issues

口 Anxious 口 Identity concerns 口 Restless

口 Cannot be in crowds 口 Impulsive 口 Seeing things

口 Cannot concentrate 口 Lack of confidence 口 Self-harm

口 Cannot sleep 口 Lack of interest 口 Sleep changes

口 Compulsive behavior 口 Nervous 口 Sleep changes

口 Depressed 口 Obsessive thinking 口 Sleep too much

口 Disturbing thoughts 口 Obsessive thinking 口 Stress

口 Eating too much or too little 口 Panic attacks 口 Talk too fast

口 Fearful 口 Suspicious 口 Tired/fatigued

口 Feeling worthless 口 Poor memory 口 Trauma

口 Food/eating changes 口 Prefer being alone

口 Grief/sadness 口 Recurring nightmares

口 Guilt

**Additional Symptoms:**

**Addiction: Level of Education**

口 Alcohol 口 Primary school

口 Opiates 口 High school 口 Graduated

口 Drugs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 口 College 口 Graduated

口 MAT 口 Graduate

口 Gambling 口 Post Graduate

口 Pornography

口 Sex **Career**

口 Shopping 口 I love my job 口 I hate my job

口 Family history of addiction 口 My job is okay 口 I need a job

**Relationships:**

口 Single 口 Married 口 Divorced 口 Separated 口 It’s complicated 口Phobic

Marriage:

口 Bad 口 Neutral 口 Good 口 Great

Family of origin:

口 Bad 口 Neutral 口 Good 口 Great

Children:

口 Bad 口 Neutral 口 Good 口 Great

Parents:

口 Bad 口 Neutral 口 Good 口 Great

Friends:

口 Bad 口 Neutral 口 Good 口 Great

Work Peers:

口 Bad 口 Neutral 口 Good 口 Great

口 Abuse

口 Conflicts

口 Stress

口 Loss

口 Finances

口 Domestic Violence

口 Sexual Trauma

口 Betrayal

**Medical Concerns:**

**Family History of Mental Health/ Addiction:**

口 None

口 who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 口 Diagnoses

Additional Information:

**Personal history of Mental Health/ Addiction**

口 None 口 Been to treatment 口 On MAT 口 Taking medications 口 Have Support

Anything else to know about personal History?

If you are currently having any thoughts of self harm or suicide its important that you seek immediate crisis intervention or suicide prevention services. For immediate assistance, dial 911 or go to your local emergency room. You can also reach out to the following resources:

* 1-800-SUICIDE - 24-hour suicide prevention line that can be called from anywhere in the U.S. https://988lifeline.org/
* If you’re uncomfortable making a phone call, you can Text HOME to 741741 to connect with a Crisis Counselor

Please note: We are not a crisis hotline. This screening tool will be reviewed and scored by a trained clinical staff member but may not be immediately reviewed at time of submission. It is important that if you are in imminent risk of suicide that you contact the resources provided.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact preferred method: Text Phone Email

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_e-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Patient authorizes Bhealthy For Life and it’s associates and affiliates to contact my emergency person including emergency services in cases of crises situations involving suicidal ideation, homicidal ideation and/or if I cannot be reached within 48 hours by other reasonable means.*

**Patient Demographics:**



**Same as Above Patient is a minor**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address same as Primary Insured

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_

**Preferred means of contact:**  

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can leave a message on Voice Mail (VM) Cannot leave a message on VM



Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can leave a message on(VM) Cannot leave a message on VM

` `

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Text: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I understand that Text communication through cell service is not HIPAA compliant and agree that this is the most efficient method of communication. I agree to text with BHealthy For Life, its associate and its affiliates. I have been given information about other protected means of communication and understand that texting does not protect my privacy rights. By my signature below I agree to text messages.*

*Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Assignment of Benefits / Financial Responsibility / Telehealth Consent**

I acknowledge the payment and insurance information set forth below and agree to pay for services rendered to me and/or facilitate the payment for services rendered to me by the providers affiliated with any of the behavioral health groups managed by Headway (Practice)

1. Payment of Fees: I agree to pay for charges for services as described in this agreement. I understand that:
   * Payment for sessions with providers affiliated with Practice is payable online through debit or credit card or ACH transfer, unless otherwise established
   * Payment for sessions is due after each session unless otherwise agreed upon and Practice will charge my card or bank account for my responsibility. Receipts may be provided at the time of the charge or monthly
   * I will be charged for sessions that I do not keep, unless I provide enough notice to the provider affiliated with the Practice (your treating provider will tell you how much notice is required to avoid being charged for sessions you do not keep)
   * I understand that I cannot submit bills for cancellations to my insurance company or managed care plan
2. Insurance and Managed Care Plans:  
   Practice participates in a number of insurance and managed care plans. If Practice participates in my plan, I agree to pay all applicable deductibles, co-payments, co-insurances and any other form of cost-sharing. If my insurance benefits run out, Practice will inform me of the ending date, and I will then be responsible for all charges dating from the end of insurance coverage. If my insurance plan denies the visit despite Practice following necessary procedures, I understand I may be responsible to pay in full for the service.
3. Assignment of Insurance Fees; Release of confidentiality for authorization of benefits and for clinical care:  
   I agree to allow my insurance plan or managed care plan to pay Practice directly, instead of paying me. In the event that my plan pays me directly, I will promptly turn the payment over to Practice unless I have already paid the charges myself. I authorize Practice to provide my insurance plan or managed care plan any information reasonably required to obtain insurance benefits and authorization for services. I authorize Practice to obtain at any time during my treatment here, any and all relevant clinical information from clinicians and facilities that have treated me and to furnish relevant clinical information to providers who will continue to treat me. I will indicate in writing any exceptions to this.
4. Consent to Treatment Via Telehealth:  
   I consent to participate in telemental health services. I understand that I have the right to refuse telemental health services and be informed of alternative services that may be available to me. If I request alternative services, I understand that Practice may not be able to provide those services, and that I may experience delays in service, the need to

travel, or any other risks associated with not having services provided via telemental health, as well as risks associated with receiving telemental health services in an off-site location. I understand that telehealth may result in certain risks that are less likely to occur with in-person services, such as technology failure, need for specialized electronic security systems, and less visibility of non-verbal cues. Telehealth can also provide benefits not present with in-person services, such as creating greater flexibility for when and where services may be provided.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card Authorization Form:**

*I hereby authorize Bhealthy For Life and associates to charge my credit card for fees incurred which include fees for appointments, appointments missed or not canceled with 24-hr notice, copays or coinsurance, or fees for completion of paperwork requested or not part of a regular appointment, including extended phone contact, per office policy.*

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Card Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Card City/ State \_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_**

**Credit Card:** Mastercard. Visa Discover Amex

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CVC: \_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date: \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Holder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Policy:**

**This notice is being sent to you, to inform you that we are H.I.P.A.A. compliant, and to describe to you an "overview" of your privacy rights.**

**The H.I.P.A.A. law was created for companies who now transfer your personal and medical information electronically (via the Internet, email, etc.) As stated previously, we do not transfer any personal and/or medical documents electronically without your consent at this time and are not foreseeing doing this in the future.**

**Our Statement to You: We acknowledge your right to your privacy and will abide by both the H.I.P.A.A. and Privacy Act laws and regulations, we understand the meaning of the word "confidential" and we respect your rights to your privacy.**

**If you have any questions or you would like to exercise any of your rights described in this brochure, you must submit your request in writing to our H.I.P.A.A. manager; or you may call and leave a detailed message and our H.I.P.A.A. manager will get back to you as soon as possible.**

**A full copy of the H.I.P.A.A. Law and regulations is located at our place of business for your review, or you can visit these Government web sites for further information:  
 www.CMS.hhs.gov/hipaa  
 www.hhs.gov/ocr/hipaa**

**www.hhs.gov/ocr/hipaa/privacy.html**

**Notice:**

**Our office does not transfer "Personal Health Information" electronically; we are however H.I.P.A.A. compliant and we are regulated by the Federal Privacy Act.**

**Our Responsibility:**

**The confidentiality of your personal health information is very important to us. All information kept in your file is confidential and will not be released unless we obtain written consent to do so and/or it is stated by the law that we may release this information without your consent.**

**What we are allowed to do without your Consent:**

**Under federal and Ohio law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. [However, the American Psychiatric Association's Principles of Medical Ethics or state law may require us to obtain your express consent before we make certain disclosures of your personal health information.] [If relevant: Participants in this organized health care arrangement also share health information with each other, as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement.]**

**Examples of these are:**

**Asking a nurse to assist with taking your temperature and to document the results. Supplying your insurance company with a diagnosis or other related health information that will assist payment for services rendered. Supplying the billing department with demographic and diagnostic information, etc.**

**Under Federal and Ohio State law, we are permitted to use and disclose personal health information without authorization, for treatment, payment, and health care operations. Note: If you are available, we will provide you an opportunity to object before disclosing any such information. If YOU are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to**

**determine what is in your best interest regarding any such disclosure. Instances where your consent is not needed. *(examples)***

* **Abuse, Neglect, or Domestic Violence**
* **Appointment reminders and other health related services (this would include leaving messages on**
* **Answering machines, unless directed not to)**
* **Business Associates such as a Billing Company**
* **Communicable Disease Control**
* **Communications with family, only if they are the responsible party for your care and/or payment**
* **Coroners, Medical Examiners, and Funeral Directors**
* **Disaster relief or to assist in disaster relief efforts**
* **Food and Drug Administration (FDA)**
* **Judicial or Administrative Proceedings**
* **Law Enforcement**There are other instances where your PMI (Personal Medical Information) may be given out. But our office policy is to always try to get permission from you first before we disclose any such information.  
    
  In general our practice will only release actual medical information, such as a diagnosis, medications you have been prescribed. Length of treatment, etc.  
    
  Session notes that document diagnoses, medications prescribed and the content of our sessions will only be released upon your signing of a specific release of information allowing me to share that information with those you designate. This is mostly done via fax. Please advise if this is not acceptable.  
     
  Your Health Information Rights:  
  Under the law, you have certain rights regarding the health information that we collect and maintain about you.

This includes the right to: *(examples)*

* **Request that we restrict certain uses and disclosures of your health information. We are not, however, required to agree to a requested restriction.**
* **Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates (if applicable). If we are unable to satisfy your request, we will tell you the reason for the denial and your right, if any, to request a review of the decision.**
* **Request that we amend or update the health information about you that is maintained in our files. This does not include therapy notes however.**
* **Request a list of whom we sent your health information to.**

**Acknowledgment of Receipt of Notice of Privacy Practices**I acknowledge and understand Bhealthy For Life and affiliates is abiding by the H.I.P.A.A., Ohio state and federal privacy act law(s) and regulations; and I hereby acknowledge that I have reviewed and/or received a copy of the Notice of Privacy Practices

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Responsible party Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

**Practice Policies**

BHealthy For Life & Affiliates: Therapists working in the clinic enjoy a collegial and educational professional relationship with several therapeutic disciplines within BHealthy For Life network. In your particular situation, your therapist works as an independently credentialed clinician through the Clinic and its affiliation Recovery For Life. Services will be billed to your insurance company via that relationship.

**Your Therapist:** Sessions with therapists are by appointment only. The best way to contact your therapist is by calling their direct phone number or sending an e-mail to the email provided by him or her. Voice mail will be checked throughout the day and at least once in the evenings and on the weekends. Practitioners strive to respond to VM within 48 hours. In the event of an emergency, please contact Riverside Hospital Behavioral Health Emergency Services at (614) 566-5056, NetCare Access at (614) 276-CARE, 911 or 988.

**Appointments:** Appointments are typically 50-60 minutes long. Missed appointments are not covered by insurance and/or may be paid out of pocket. There is a $60 no show fee if there is not 24 hours notice of a cancellation.

**Payments & Insurance:** Co-payments are due at the time of the appointment. Payments can be given to the therapist. We do not accept checks. If you are unsure about your balance or have any questions regarding billing, please contact Supervising practitioner Virginia Clagg at virginia.clagg@bhealthyforlife.com.

**Confidentiality:** Everything that takes place in psychotherapy is confidential and may not be released without your expressed written permission. There are two exceptions to this: if you or your child becomes a danger to self or others; and if you or your child is involved in child abuse. In these situations, we are legally bound to break confidentiality in order to protect all involved. Confidentiality for children and adolescents in situations other than those listed above will be discussed with you during the evaluation phase of treatment.

By signing this document, I understand and agree with the policies described above. I also understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. If my account is more than 90 days in arrears, I authorize that pertinent billing information can be released to a professional service for purposes of collection of the outstanding balances. 

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I am patients Guardian

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

**Informed Consent:**

**About psychotherapy services**

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.

As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Please note that psychotherapy is not an emergency service. If you are experiencing suicidal or homicidal thoughts, are in crisis, or need immediate help, please call 911 or go to the nearest emergency department.

**Benefits and risks of psychotherapy**

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems.

Note that there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

**The first few sessions**

The first few sessions typically involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Appointments and cancellations

Appointments are typically held at the same time each week, at a cadence we agree on (such as weekly or every other week). Payments for each appointment can be made through Headway by debit or credit card or ACH transfer.

You may cancel appointments in advance free of charge, as long as I receive notice within 48 hours. For appointment no-shows or last-minute cancellations, you will be charged a $60 fee. Please reach out to me directly for my latest policy on the cancellation cutoff period and fees.

**Professional Records**

I am required to keep appropriate records of the psychological services that I provide. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

**Confidentiality**

Communication between you and your counselor is confidential. This means that your counselor will not discuss your case orally or in writing without your expressed written permission.

Your counselor has an ethical and legal obligation to break confidentiality under the following circumstances:

1. If there is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect.
2. 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.
3. 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.
4. If you introduce your emotional condition into a legal proceeding.
5. If there is a court order for release of your records.

**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, with the exception of payment of fees for services already provided. You have the right to question any aspect of your treatment with your therapist.

1. You also have the right to expect that your therapist will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you.
2. If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist.
3. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, or national origin.
4. You have the right to ask questions about any aspects of therapy and about my specific training and experience.
5. In circumstances that lead me to conclude that your counseling needs would be better served at another counseling facility, I will suggest an appropriate counselor(s) or counseling agency.
6. Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to us to provide counseling services and that this contract is binding for all future sessions you may have with this entity.

I have read and agree to the above documentBy clicking the checkbox I acknowledge I have read the information provided above. By clicking the button, “Sign and acknowledge” I am signing and agreeing to the terms outlined in the document above.

**Consent for Treatment**

I give my consent to receive treatment and related services from (Practitioner name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that this consent is for the duration of the services provided.

Client Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Minor Consent to TreatI give my consent as parent or guardian for the following individual to receive treatment and related services from BHealthy For Life and Recovery For Life its affiliates, partners and subsidiaries. I understand that this consent is for the duration of the services provided.**

**Release of Information**

I hereby authorize (Name of practitioner): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to exchange my protected personal Information with (organization): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of patient or client): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Date of birth): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**** Information to be exchanged:

**** Evaluation

**** progress/therapy notes

**** Summary of treatment. This may contain information that includes alcohol and drug use

**** Other (Listed, if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information is for the following purpose:

**** For coordination of care

**** Other (Listed, if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to your therapist/BHealthy for Life & Affiliates. I understand that your therapist/BHealthy for Life & Affiliates may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Guardian**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have agreed to outdoor counseling, or a therapy session that takes place outside of my counselor’s office. This form serves as a supplement to the general informed consent I signed when initiating services. I am aware that outdoor counseling may take several forms. It may involve sitting outdoors on a bench outside of the office or sitting in a public place. It may also take the form of walking/moving while addressing therapeutic goals and

topics.

By signing this form, I agree to the following:

1. You understand that participation in outdoor therapy is completely voluntary and that there are alternative options such as teletherapy or in-office services available.

2. I agree that I am responsible for selecting the location and/or setting the physical pace of the outdoor session.

3. I understand that this is not exercise or athletic/personal training, and that while movement may benefit me physically, the focus will remain therapeutic in nature.

4. I agree to communicate with my counselor if I am uncomfortable physically or emotionally while participating in outdoor counseling. In such a case, the outdoor session would discontinue outside and would instead continue in the BHFL/ RFL office.

5. I agree that the counselor has the right to terminate the outdoor therapy session and return to their office at any time based on clinical judgment.

6. I take full responsibility for my medical and physical well-being and will not hold Counseling Services with BHealthy For Life legally or financially responsible for any medical conditions and/or accidents that may arise during outdoor therapy.

7. If I have any medical conditions that could arise or be detrimental during outdoor therapy, I agree to obtain approval from my doctor and will disclose information relevant to this condition to my counselor prior to engaging in outdoor counseling.

8. I understand that while my counselor will take reasonable steps to ensure the confidentiality and privacy **d**uring my outdoor counseling appointment, there is a risk that my session will be less private than an appointment at

BHealthy for Life/ Recovery For Life.

For example:

a. I understand that if the counselor and I encounter a person I know, I have the right to

disclose or not to disclose that I am receiving services and/or the relationship with my counselor. I understand that the counselor will defer to my decision, should this situation arise.

b. I understand that if the counselor should encounter a person they know, they will not acknowledge me as a client to preserve confidentiality.

c. I understand that both the counselor and I will be visible to the public, and that being seen may lead to assumptions that I am connected to NAU CS. I consent to taking this risk.

d. Given the prevalence of cellphones, it is also possible that I may be photographed or videoed with my therapist without my knowledge and that myself or my therapist would have no control over the dissemination of those photos/videos. Perceived informality of the interaction.

Although outdoor therapy might feel more like a social interaction rather than a therapeutic interaction, it is a therapeutic activity. Despite the relative informality of the

interaction, the relationship between client and therapist will remain entirely professional and not social in nature.

10. This consent can be withdrawn at any time by submitting a request in writing to your counselor.

11. If I have any questions regarding anything in this document, I will request clarification from my counselor prior to signing.

By signing below, I understand that I am consenting to the above-mentioned conditions and risks regarding Outdoor Therapy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client: Date:

\*Outdoor Therapy is an option for this specific counselor and is in no way reflective of the services provided by other BHFL/ RFL counselors.

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