BOYS TOWN
Saving Children Healing Families

Client Name _____

Behavioral Health Clinic Agreement and Consent for Services

Please read and review the following pages for an explanation of our office policies and keep them for your reference.

Please Initial:

FINANCIAL RESPONSIBILITY AND PAYMENT POLICY

1. _____ I agree that I am responsible for payment of all charges for mental health services provided to me, including any copayments or deductibles. I understand that I am responsible for notification at the time of the visit of any benefit changes in my insurance plan. I further understand that I am responsible for any service provided to me that is not covered by my policy. I accept financial responsibility for the services provided to me by the Boys Town Behavioral Health Clinic.

NOTICE OF PRIVACY AND CLIENT RIGHTS

2. _____ I have received the Boys Town Notice of Privacy, which describes how confidential health information about the client may be used or disclosed and how to get access to this information. I have also received a copy of the Boys Town Behavioral Health Clinic Client Rights & Responsibilities.

CONSENT TO TREATMENT

3. _____ The Boys Town Behavioral Health Clinic works with children and their families to identify and treat such issues as depression, anxiety, school problems, and ADHD. The Behavioral Health Clinic offers specialized services, including behavioral and psychological assessments as well as counseling. I, knowing that the client has a condition requiring diagnosis and treatment, do hereby voluntarily consent to such treatment by the Behavioral Health Clinic staff, assistants, or designees as is, in their judgment, necessary. I further acknowledge that no guarantees have been made to me as to the results of treatment. I authorize you to provide reasonable and proper care by today's standards. If applicable, I have informed my treating provider of my mental health advance directives and have provided a copy for mental health decision-making that will become part of my treatment record.

CONTACT BY TELEPHONE and EMAIL

4. _____ I understand that by providing my landline or mobile number(s), I give my consent for the Behavioral Health Clinic, their agents, and their collection agents to contact me at these numbers, or at any number that is later acquired for me, and to leave live or pre-recorded messages, or voice or text messages, regarding any accounts or services. For greater efficiency, calls may be delivered by an autodialer. Providing a telephone (landline or mobile) number is not a condition of receiving services.

You may contact me by email:	Yes ____	No ____	Email address:	_____
You may contact me by text:	Yes ____	No ____	Phone number:	_____
You may contact me by phone:	Yes ____	No ____		
You may leave a message on my phone:	Yes ____	No ____		

PERMISSION TO FURNISH INFORMATION FROM RECORDS

(***Please initial one)***

5. _____ - **YES** I understand that certain medical information regarding the client may need to be released by the Behavioral Health Clinic to third-party payers in order to obtain payment for the services provided. I hereby authorize and request the Boys Town Behavioral Health clinic staff to furnish medical information requested by the health insurance carrier or any other third-party payer. I authorize contact with my insurance company or health plan administrator to obtain all pertinent financial information concerning coverage and payments under my policy, and I authorize my insurance company or health plan administrator to release information to the Boys Town Behavioral Health Clinic.

_____ - **NO** I understand that even though I may have insurance that covers these services, I have selected to be financially responsible rather than submit to my insurance carrier.

COORDINATION OF CARE

6. _____ I understand that in order to provide the highest level of care, the Behavioral Health Clinic may request permission to discuss relevant aspects of care with other providers serving the client. Such providers may include but are not limited to: physicians, school personnel, and previous mental health providers. When contact with other providers is requested, a separate Authorization for the Release of Information will be completed and signed for each provider. If your clinician may communicate with the client's primary care provider (physician) about today's appointment, please sign the attached Authorization for the Release of Information Primary Care Provider form and return it with this form.

STATEMENT OF UNDERSTANDING

Signing below indicates that I have read or have had read to me the contents of this document and have received pertinent information regarding Office Policies, Client Rights & Responsibilities, and Notice of Privacy. I agree to abide by the stated terms and conditions of service provision. I agree that these provisions will remain in effect until I provide written revocation to the Behavioral Health Clinic. If I am signing for someone other than myself, I represent that I have legal authority to do so.

Print Client Name (If a minor, person authorized to sign for Client)	Signature of Client (if a minor, person authorized to sign for Client)	Relationship to Client	Date