BIRCHWOOD
behavioral health

Outpatient Psychotherapy Informed Consent

Client: _____

Date of Birth:_____

This document includes important information about the therapy process and the rights of the client. Please read this document carefully and ask questions you may have. Initial on the line next to each section to indicate you have read and understand the section.

____ PSYCHOLOGICAL SERVICES

Outpatient psychotherapy services offered by Birchwood Behavioral Health include Individual, Family, and Group Therapy, as well as parenting classes. The techniques used during these sessions will vary. However, all clinicians at Birchwood Behavioral Health use evidence based practices and have a strengths-based perspective. All clinicians providing outpatient psychotherapy services at Birchwood Behavioral Health are Master's Level therapists.

A treatment plan will be developed on the day services begin, unless a treatment plan is being carried over from residential care at BBH. The treatment plan will outline the client goals and objectives, which will subsequently determine the course of treatment. Treatment plans will be renewed every 90 days.

____ RISKS AND BENEFITS

Psychotherapy is a process that has both benefits and risks. Some of the risks involved in therapy could include experiencing uncomfortable or painful feelings such as anger, sadness, and guilt. However, psychotherapy has many benefits as well. Psychotherapy can increase communication skills, improve relationships, increase insight and awareness, provide skills for coping with stress and resolving conflict, and create a sense of hope. However, there are no guarantees that psychotherapy will have any specific desired effect. The therapeutic success relies heavily on the participation and effort of the client.

____ FEES

Licensed Master's Level Clinician
Initial Intake (90 min): $309
45-50 min session: $150
60 min session: $180
60-90 min session: $225

Fees also apply to the preparation of assessment and other reports, telephone conversations, consultations, or meetings you have authorized as part of your counseling process. Insurance will be billed if eligible. Insurance co-pays are due at the time of visit. If insurance does not pay, clients are responsible for their bill.

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____ **CANCELLATIONS**

Clients are responsible for informing the front desk within 24 hours if they are unable to attend their scheduled appointment. There is a $50 fee for late cancellation or not attending a scheduled appointment. After three “no-call, no-show” sessions (where advanced notice was not given of the cancellation), services are eligible to be terminated. If a client is unable to be reached for three consecutive “no show” sessions, services are eligible to be terminated.

____ **CONFIDENTIALITY**

Client progress in treatment, the content of therapy sessions, and any information provided to BBH over the course of treatment is protected by legal confidentiality. Some exceptions to confidentiality are the following situations in which BBH may choose to, or be required to, disclose this information:

- The State of Alaska Medicaid program and other insurance carriers require us to disclose client’s eligibility criteria and diagnosis to cover the cost of treatment at BBH
- If the client/guardian gives written consent to release the information to another party
- If the client discloses the intention to seriously harm themselves
- If the client discloses the intention to seriously harm another identified person
- If the client discloses the abuse (current or past) of a child, elderly person, or other vulnerable person
- If a judge or court orders the release of records

____ **PRIVACY DISCLAIMER**

Our Clinicians receive additional supervision from licensed mental health professionals in order to provide our clients with the best services possible. Please note that they may disclose identifying information about a therapy session in consultation with their supervisor. In addition, BBH clinicians practice case consultation with the BBH clinical team. However, all confidentiality practices explained above will be applied to ensure client privacy is maintained.

____ **RECORD KEEPING**

BBH clinicians are required to keep records of all psychotherapy sessions. These records include the fact that you attended the session, client goals and progress, interventions used, and a brief synopsis of content discussed. The records are kept in a secure location at BBH. Clients have a right to request copies of their records. Records will not be released without the client’s written permission, with the exception of the situations outlined in the Confidentiality section above.

____ **THERAPIST INFORMATION**

I received information about my therapist’s qualifications.

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____ **OTHER RIGHTS**

Clients have the right to ask questions about what is happening in therapy at any time. Clients have the right to end therapy at any time. Clients also have the right to end therapy at BBH and be referred to another therapist. In this case, appropriate referrals will be given so that they can continue therapy with another provider. Clients also have the right to a safe therapeutic environment, free from discrimination based on race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or social class

CLIENT CONSENT

☐ I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in outpatient psychotherapy. I understand that I may withdraw from counseling at any time.

_____ _____

Client Signature Date

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Outpatient Psychotherapy
Adult Intake

General Information	
Name:_____ SS#:_____ DOB:_____ Work Phone:_____ Home Phone:_____ Cell Phone:_____ Address:_____	Email:_____ Gender:_____ Sexual Orientation:_____ Ethnicity:_____ Primary Language:_____ Special Needs:_____ Church Attended:_____
Confidential Phone # (can be from above):_____ *In order to respect your privacy, BBH needs a number where messages can be left with our information. How did you hear about Birchwood Behavioral Health?_____	
Insurance Information Subscriber Name:_____ Relationship to Subscriber:_____ DOB:_____ ID#:_____	 Insurance Provider:_____ Insurance Phone:_____ Address:_____ Group ID#:_____

Outpatient Psychotherapy Adult Intake

Family History

Are you married?___Yes ___No If yes, how long?_____
Do you have children?___Yes ___No If yes, provide details:_____
Who do you currently live with?_____
Where do you live and how long have you lived there?_____
Are things okay at your home?_____
Religious Orientation:_____
Cultural Beliefs:_____
Do you have any relationships that are supportive/loving?_____

As a child, did you stay with your family of origin or did you move to different caregivers (i.e. foster homes, adoption, treatment centers, etc.)?_____
_____
_____
Family history of substance abuse?_____
Family history of mental health disorders?_____
_____
Family history of significant medical problems?_____
_____

Social History

How many close friends do you have?_____
Do you prefer to be alone or with others?_____
What are your interests, hobbies, and recreational activities?_____
_____
Do you have any activities that connect you to people in the community?_____
_____

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Outpatient Psychotherapy
Adult Intake

Work History

Are you presently employed?___Yes ___No
If yes, where and how many hours?_____
Past employment:_____
If no, how do you support yourself?_____

Medical History

Name of current physician:_____ Phone:_____
Date of last exam or physical:_____
Has you ever been hospitalized?___Yes ___No
If yes, please describe:_____
Do you have any of the following medical conditions?

___AIDS
___Allergies
___Colic
___Headaches
___High Fever
___Seizures
___Vision
___Anemia
___Brain Injuries
___Dizziness
___Head Injuries
___Influenza
___Skin Problems
___Other
___Asthma
___Cancer
___Ear Infections
___Hearing Problems
___Pneumonia
___Tuberculosis

Please briefly describe any checked medical conditions:_____
_____
List any other medical conditions:_____
_____
List all medications being taken:_____
_____
List all psychiatric medications you have been on in the past:_____
_____
List any diets or exercise programs:_____

Legal History

Have you ever had any legal problems?___Yes ___No
If yes, please describe (when, where, what):_____
_____
Do you have a probation officer?___Yes ___No
If yes, name and phone number:_____

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Outpatient Psychotherapy
Adult Intake

Addiction/Substance Use

History:___Yes ___No
Current use: ___Yes ___No
Circle if applicable: (Alcohol) (Drugs) (Gambling) (Eating Disorder) (Sexual Compulsivity)
Substances:_____
Frequency:_____
Longest period of sobriety:_____
Length of use:_____
Prior treatment:_____

Mental Health

Have you ever been to therapy before?___Yes ___No
If yes, when and where?_____
Was it helpful?_____
Have you been diagnosed with a mental health disorder in the past?___Yes ___No
If yes, please describe:_____
Have you ever been hospitalized due to mental health concerns?___Yes ___No
If yes, please describe:_____

State in your own words what has brought you to counseling:

_____
_____
_____

To the best of my knowledge, the information provided is accurate and true.

I agree to counseling treatment at Birchwood Behavioral Health.

Date:_____ Signature:_____

Authorization for Exchange of Information

I hereby authorize Birchwood Behavioral Health to exchange personal health information between: **Birchwood Behavioral Health** and _____ regarding:

Client: _____

Date of Birth:_____

Please check specific information to be released:

- ☐ Verbal exchange of all information to aid in assessing and/or treating the client
- ☐ Clinical Summaries
- ☐ Continuing Care Plans
- ☐ Intake Assessments
- ☐ Psychiatric Reviews
- ☐ Psychological Evaluations
- ☐ Neuropsychological Evaluations
- ☐ Substance Abuse Assessments
- ☐ Clinical and Laboratory Results
- ☐ Discharge Summaries
- ☐ Immunization Records
- ☐ Medical History/Physical Exams
- ☐ Transcripts, Academic & School Behavior Records, Special Education Records
- ☐ Progress Notes
- ☐ Treatment Plans
- ☐ UA Results

This information may be used for the continuation of care. I understand that this authorization will expire 12 months from the date signed, with revocation of custodian/guardianship or upon written revocation, whichever comes first. This authorization may be revoked prior to the expiration, but not retroactively. Photo static and/or facsimile copies of this authorization will be considered as valid as the original.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations restrict any use of this information to investigate or prosecute any alcohol or drug abuse patient. Disclosure of patient information is permitted with the patient's written consent: however, disclosures to central registries and in connection with criminal justice referrals must meet the following specific regulations (CFR 2.32 and 2.33). This information disseminated from Birchwood Behavioral Health.

I acknowledge that the information to be released is protected by federal law and may include information regarding drug/alcohol abuse, sexually transmitted diseases/HIV and/or Hepatitis B. My signature below authorizes the exchange of this information. I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand that once the above information is disclosed, it may be subject to redisclosure by the recipient and no longer protected by federal privacy laws or regulations.

_____ _____

Client Signature Date