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<br>(If a minor, person authorized to sign for Client) | Signature of Client<br>(if a minor, person authorized to sign for Client) | Relationship to Client | Date |

Behavioral Health Clinic

## Authorization to Release / Request Confidential Information To Primary Care Provider

Client Name: ______________________________ Date of Birth: ______________

☐ Released and/or ☐ Requested

☐ I do authorize Boys Town to contact/communicate with my child's / my Primary Care Provider.
☐ I do **NOT** authorize Boys Town to contact/communicate with my child's / my Primary Care Provider.

**To / From (of Primary Care Provider / Clinic)**

Name: ______________________________

Clinic ______________________________

Address: ______________________________

Phone: ______________________ Fax: ______________________

*email address is only required if this is the means of disclosure*

Email address: ______________________________

**Release Format:** ☐ Paper ☐ Electronic

**Release Method:** (check all that apply): ☐Email ☐ Mail ☐ Fax ☐ Pick up ☐Verbal ☐ Other: ______________

**By signing this authorization form, I understand that:**

- I have the right to revoke this authorization at any time. Revocation must be made in writing to Boys Town Records, at the address listed below. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless revoked, this authorization will expire in one (1) year from the date signed or on the following date/event whichever occurs sooner. Date ______________ or Event ______________________________
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information has the potential for re-disclosure, and may not be protected by federal confidentiality rules.
- Requests for copies of records may be subject to fees in accordance with applicable law.
- If I request release by unencrypted email or another unsecure method, I have been warned of and accept the security risks to the information associated with the unsecure transmission, and Boys Town is not responsible for breach notification or liable for disclosures that occur in transit.

| ______________________ | ______________________ | ______________________ | ____________ |
|---|---|---|---|
| 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 |

**Boys Town Records:** 5074 Ames Ave, Omaha, NE 68104

**Phone Number**: 402-996-2540
**Fax Number**: 402-996-2599

## Risk of using email

Transmitting client information by email has a number of risks that the client or legal guardian (email recipient) should consider before using email. These include, but are not limited to, the following risks:

- Email can be circulated, forwarded, and stored in numerous pages and electronic files.
- Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- Email senders can easily misaddress an email.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of email may exist even after the sender of the recipients has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect emails transmitted through their systems.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used to introduce viruses into computer systems.
- Email can be used as evidence in court.
- Email on shared email accounts can be viewed by more than the intended recipient.

## Conditions for the use of email

Boys Town Behavioral Health will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, Boys Town Behavioral Health cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not caused by Boys Town Behavioral Health's intentional misconduct. Thus, email recipients must consent to the use of email for treatment information. Consent to the use of email includes agreement with the following conditions:

- All emails to or from the email recipients concerning diagnosis or treatment will be printed out and made part of the client's records, and other individuals authorized to access the client records, such as staff and billing personnel, will have access to those emails.
- Boys Town Behavioral Health may forward emails internally to its staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling and/or as otherwise permitted by contract or applicable law. Boys Town Behavioral Health will not, however, forward emails to independent third parties without the client's/legal guardian's prior written consent, except as authorized or required by law.
- Although Boys Town Behavioral Health will endeavor to read and respond promptly to an email from an email recipient, Boys Town Behavioral Health cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, an email recipient shall not use email for medical emergencies or other time-sensitive matters.
- If an email recipient's email requires or invites a response from Boys Town Behavioral Health, and the email recipient has not received a response within a reasonable time period, it is the email recipient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
- The email recipient is responsible for informing Boys Town Behavioral Health of any types of information he/she does not want to be sent by email.
- The email recipient is responsible for protecting his/her own password or other means of access to email. Boys Town Behavioral Health is not liable for breaches of confidentiality caused by the client, his/her parent(s) or legal guardian(s), or any third party.
- It is the email recipient's responsibility to follow up and/or schedule an appointment if warranted.

## Guidelines for email communication

To communicate by email, the email recipient shall:

- Inform Boys Town Behavioral Health of changes to his/her email address.
- Put the client's name and date of birth in the body of the email, not in the subject line.
- Withdraw consent only by written communication.
- Include the category of the communication in the email's subject line, for routing purposes (e.g., billing question).
- Review the email to make sure it is clear and that only relevant information is provided before sending to Boys Town Behavioral Health.
- Limit disclosure of treatment and sensitive information regarding client in the email.
- Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding his/her computer password.

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# Behavioral Health Clinic
# Client Information Sheet

## Client Information

| | | | |
|---|---|---|---|
| Last Name: | First: | MI: | Birth Date: |
| Address: | City: | State: | Zip: |
| Home Phone: Work Phone: | Marital Status: M D S W | Gender: ☐ M ☐ F | Is Client Currently a Student? ☐ Yes ☐ No |
| Primary Care Physician: | Referring Physician: | | |

Person to Notify in Case of Emergency (friend or relative not living with you):

*Name* *Relationship* *Phone*

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to Answer

Ethnicity: ☐ Hispanic/Latino Origin ☐ Not Hispanic/Latino Origin ☐ Decline to Answer ☐ Unknown

| Responsible Party (Legal Guardian) | Spouse/Other Parent |
|---|---|
| Last Name: First: M.I.: Birth Date: | Last Name: First: M.I.: Birth Date: |
| Address: | Address: |
| City: State: Zip: | City: State: Zip: |
| Home Phone: Work Phone: Cell Phone: | Home Phone: Work Phone: Cell Phone: |
| E-mail Address: Relationship to Client: | E-mail Address: Relationship to Client: |
| Circle One: Employed Unemployed Disabled Retired | Circle One: Employed Unemployed Disabled Retired |
| Employer Name: | Employer Name: |
| Employer Address: Phone: | Employer Address: Phone: |

| Primary Insurance Information | Secondary Insurance Information |
|---|---|
| Insurance Co. Name: | Insurance Co. Name: |
| Insured's Name: | Insured's Name: |
| Relationship to Client: | Relationship to Client: |
| Policy #: Group #: | Policy #: Group #: |
| Effective Date: Insurance Phone #: | Effective Date: Insurance Phone #: |

Your signature indicates that the above information is accurate and reflective of your current insurance information. You understand that you are responsible for any copayments or deductibles at each appointment. By signing below, you also understand that the benefit information that our office staff obtained is a courtesy and is NOT a guarantee that insurance will pay for the services provided. Further, you understand that you are responsible for any amount due that is not covered by your insurance provider, and you understand that the Clinic will bill you for any outstanding amounts owed. **You are responsible for reporting any insurance changes to the front desk staff at the time of your appointment.**

Name of responsible party     Signature of responsible party     Date

## Behavioral Health Clinic
## E-mail Information Form

**Risk of using e-mail**

Transmitting client information by e-mail has a number of risks that the client or legal guardian (e-mail recipient) should consider before using e-mail. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded, and stored in numerous pages and electronic files.
- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- E-mail senders can easily misaddress an e-mail.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender of the recipients has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.
- E-mail on shared e-mail accounts can be viewed by more than the intended recipient.

**Conditions for the use of e-mail**

Boys Town Behavioral Health will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Boys Town Behavioral Health cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Boys Town Behavioral Health's intentional misconduct. Thus, e-mail recipients must consent to the use of e-mail for treatment information. Consent to the use of e-mail includes agreement with the following conditions:

- All e-mails to or from the e-mail recipients concerning diagnosis or treatment will be printed out and made part of the client's records, and other individuals authorized to access the client records, such as staff and billing personnel, will have access to those e-mails.
- Boys Town Behavioral Health may forward e-mails internally to its staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling and/or as otherwise permitted by contract or applicable law. Boys Town Behavioral Health will not, however, forward e-mails to independent third parties without the client's/legal guardian's prior written consent, except as authorized or required by law.
- Although Boys Town Behavioral Health will endeavor to read and respond promptly to an e-mail from an e-mail recipient, Boys Town Behavioral Health cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, an e-mail recipient shall not use e-mail for medical emergencies or other time-sensitive matters.
- If an e-mail recipient's e-mail requires or invites a response from Boys Town Behavioral Health, and the e-mail recipient has not received a response within a reasonable time period, it is the e-mail recipient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- The e-mail recipient is responsible for informing Boys Town Behavioral Health of any types of information he/she does not want to be sent by e-mail.
- The e-mail recipient is responsible for protecting his/her own password or other means of access to e-mail. Boys Town Behavioral Health is not liable for breaches of confidentiality caused by the client, his/her parent(s) or legal guardian(s), or any third party.
- It is the e-mail recipient's responsibility to follow up and/or schedule an appointment if warranted.

3. **Guidelines for e-mail communication**

To communicate by e-mail, the e-mail recipient shall:

- Inform Boys Town Behavioral Health of changes to his/her e-mail address.
- Put the client's name and date of birth in the body of the e-mail, not in the subject line.
- Withdraw consent only by written communication to Boys Town Behavioral Health.

## Behavioral Health Clinic
## E-mail Information Form

- Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
- Review the e-mail to make sure it is clear and that only relevant information is provided before sending to Boys Town Behavioral Health.
- Limit disclosure of treatment and sensitive information regarding client in the e-mail.
- Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.

**Acknowledgment and Agreement**
I, whether for myself or on behalf of the below-identified client, acknowledge that I have read and fully understand the risks associated with the e-mail communication between Boys Town and me. I consent to the conditions outlined above. In addition, I agree to these guidelines, as well as any other conditions or guidelines that Boys Town Behavioral Health may impose to communicate with e-mail recipients by e-mail. Any questions I had were answered.

| ______________________ | ______________________ | ______________________ | __________ |
|---|---|---|---|
| Print Client Name<br>(If a minor, person authorized to sign for Client) | Signature of Client<br>(if a minor, person authorized to sign for Client) | Relationship to Client | Date |

Providing a valid email address below authorizes e-mail communication between the Client or Legal Guardian listed above and the client's therapist.

<u>All other authorizations regarding e-mail communication with interested third parties require completion of Behavioral Health Clinic Authorization to Release Confidential Information</u>.

Name of Client: ______________________ Date of Birth ______________________
Name of email recipient: ______________________________________________
Email Address: ______________________________________________

BOYS TOWN.

**Behavioral Health Clinic**
**Pretreatment Questionnaire**

Client Name: ______________________ DOB: __________ Date: __________ M ☐ F ☐

Race: American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐
Native Hawaiian or Other Pacific Islander ☐ Other ☐ Decline to Answer ☐

Ethnicity: Hispanic or Latino Origin ☐ Not Hispanic or Latino Origin ☐ Decline to answer ☐ Unknown ☐

Form completed by: Self ☐ Parent ☐ Other ☐ ______________________
Relationship to client

Referred by: Physician ☐ Employer ☐ Relative ☐ Friend ☐ Website ☐
Other: ☐ ______________________

Primary concern(s) for which treatment is sought: ______________________

**1. Please rate your child on each of the areas below AND whether it has been a problem during the last month:**

| | **Extremely Poor** | | | **OK** | | | **Extremely Well** | **Is this a problem?** | |
|---|---|---|---|---|---|---|---|---|---|
| Getting along with family | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **Yes** | **No** |
| Getting along with other peers/children outside of the home | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **Yes** | **No** |
| Getting along with other adults outside of the home | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **Yes** | **No** |
| Performance at school/work | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **Yes** | **No** |

**2. Please rate your child on each of the areas below AND whether it has been a problem during the last month:**

| | **Never** | | | **Sometimes** | | | **Always** | **Is this a problem?** | |
|---|---|---|---|---|---|---|---|---|---|
| Overactive, acts without thinking | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **Yes** | **No** |
| Sad, unhappy, down, or depressed | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **Yes** | **No** |
| Worried, nervous, and/or anxious | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **Yes** | **No** |
| Difficulties with school (academics and/or behavior) | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **Yes** | **No** |
| Sleeping problems | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **Yes** | **No** |
| Problems with temper, having a 'short fuse' | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **Yes** | **No** |
| Difficulty tolerating frustration/change | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **Yes** | **No** |
| Problems with peers | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **Yes** | **No** |
| Other: ______________ | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **Yes** | **No** |
| Other: ______________ | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **Yes** | **No** |

| Clinician Use: | | Int | | Ext | | Comb | | Oth |
|---|---|---|---|---|---|---|---|---|

BOYS TOWN

**Behavioral Health Clinic**
**Pretreatment Questionnaire**

**Individuals living with child/youth:**

Name: ______ Age: ______ Relationship: ______
Name: ______ Age: ______ Relationship: ______
Name: ______ Age: ______ Relationship: ______
Name: ______ Age: ______ Relationship: ______

**Divorced/Separated/Not Living Together:** No ☐ Yes ☐ If yes, please note above who (adults and children) lives with your child in each residence. Also, please describe current parenting schedule/time spent in each household:

**Educational history:**

Current school: ______ Current grade: ______
Special education placement? No ☐ Yes ☐ If yes, in what area? ______
Has the school performed psychological testing? No ☐ Yes ☐ If yes, when? ______
Is there an IEP (Individual Educational Plan)? No ☐ Yes ☐ Don't know ☐ ______

**Child's interests/activities:** ______

**What are your child's strengths?** ______

**Previous mental health treatment:** No ☐ Yes ☐ If yes, please detail below:
Mo/Yr ______ Provider ______ Treatment ______ Outcome ______
Mo/Yr ______ Provider ______ Treatment ______ Outcome ______

**Current legal concerns:** No ☐ Yes ☐ If yes, please explain: ______

**Past History of abuse:** No ☐ Yes ☐ If yes, please explain: ______

**Religious/spiritual affiliation(s):** ______ None ☐ Prefer not to answer ☐

**Developmental history:**
Complications at birth or in early childhood? No ☐ Yes ☐ If yes, please explain: ______

**Medical diagnoses and conditions:** None ☐ Yes ☐ List: ______

**Significant operations/invasive procedures** None ☐ Yes ☐ List: ______

**Serious injuries/chronic illnesses/hospitalizations:** None ☐ Yes ☐ List: ______

**Behavioral Health Clinic**
**Pretreatment Questionnaire**

**Last visit to doctor / well-check date:** ______________ Doctor's name: ______________

**Allergies:** None ☐ Yes ☐ List: ______________

**Immunizations current** Yes ☐ No ☐ If no, please explain ______________

**Medications (prescribed and over-the-counter):** None ☐

Medication ________ Dosage ________ Prescribing Physician ________ Started ________
Medication ________ Dosage ________ Prescribing Physician ________ Started ________
Medication ________ Dosage ________ Prescribing Physician ________ Started ________
Medication ________ Dosage ________ Prescribing Physician ________ Started ________
Date of last medication check. ______________

**Adverse drug reactions:** None ☐ Other ☐ ______________

**Substance use:**

**Alcohol Use:** None ☐ Suspected ☐ Known to use currently ☐ Recovering ☐
Type: ________ Amount: ________ How often? ________

**Drug Use:** None ☐ Suspected ☐ Known to use currently ☐ Recovering ☐
Type: ________ Amount: ________ How often? ________

| | | | |
|---|---|---|---|
| Client Name (if not a minor) | | Signature of Client | Date |
| Legal Guardian Name (Print) | Relationship (e.g., mother, father, etc.) | Signature of Legal Guardian | Date |