SERENITY

BEHAVIORAL HEALTH SERVICES

Receipt of Understanding and Inform Consent for Treatment

Client Name: _____ **Client Name:** _____

Acknowledgment of receipt and understanding:

I certify that Serenity-BHS has provided me with a copy of the Client Welcome Packet. I have read and understand the following items. I have the ability to make decisions in regards to my own healthcare needs.

Welcome Packet which includes: Introduction to Serenity-BHS Fees for Services Client Rights HIPPA Office hours Policies and Procedures	**Staff Disclosure Form**
E-Therapy Notice & Consent	**Release of Information Form**

Inform Consent for treatment:

I give my consent for an assessment of what brings me to therapy. I understand that an assessment will include doing some paperwork during the first two sessions with my therapist. I also consent for treatment as outlined in my treatment plan that I will develop with my therapist within the first 30 days of treatment. I understand that this consent is for the duration of the services to be provided. I understand that treatment will involve talking about my personal thoughts, feelings, and experiences. I understand that therapy may cause some additional stress/emotions during the course of learning how to resolve or address your presenting problems. I understand that my therapist will help me process my feelings/thoughts during my sessions. I understand that if a crisis occurs as it relates to my mental health treatment, that I can contact Netcare Access for assistance at any time. I also understand that my therapist may ask to refer me to external medical services if they feel it is necessary to meet my therapeutic needs. Such referrals may include a medical or psychiatric assessments.

I understand that I need to give at least a 24 hour notice if I intend to cancel my therapy session in order to avoid paying the cancelation fee $50.00. I understand that I have a right to terminate treatment at any time.

I consent to communications between myself and my therapist through the use of phone calls, cell phone texting and emails in order to schedule or re-scheduling appointments. I understand that I should only communicate non-confidential information via texting with my therapists and that texting is not a form of treatment.

I understand that my therapist and the staff of Serenity-BHS are committed to maintaining confidentiality except in cases where intervention is a professional or legal mandate, including the following:

1. Any threat to harm myself or others, including murder, suicide, and assault.
2. Any reports of actual or suspected child abuse, endangerment or neglect.
3. Any reports, actual or suspected, of abuse of the elderly or dependent adult.
4. Clinician is court ordered to testify.
5. Guardian or legal custodial parent requests information.

Your clinician may discuss cases with professional colleagues, without use of names, as deemed necessary. However, your therapist will always abide by the rules as outlined in our agency's policies, their State Licensing Board rules and per HIPPA.

I give consent for Serenity-BHS to bill me and/or my health care insurance company for the cost of services.

_____ _____

Signature of Client, Parent, or Legal Guardian Date

_____ _____

Signature of Witness Date

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www.serenity-bhs.org