Informed Consent for Treatment

Client Name_____

Client DOB_____

Qualifications and Team Approach

Thank you for choosing TeamBuilders Behavioral Health (hereafter "TeamBuilders") for your or your child's behavioral health service needs. TeamBuilders consists of a team of licensed mental health professionals including clinical therapists, psychologists, substance abuse counselors, other behavioral health care providers who work together with you or your child and other community practitioners who also serve you or your child in order to meet your medical and therapy needs.

TeamBuilders accepts only clients and families who have the capacity to resolve their own problems with our assistance. We will discuss and decide on the methods that are best for you and your circumstance. You may obtain a second opinion from another professional if you prefer to do so. We will discuss your preferences and needs and develop an individualized plan for you or your child. We will also meet as a professional team to consult about your case, as indicated, so that we can deliver the best possible therapeutic care. We also work in communication with your or your child's primary care physician as needed.

Consent for Treatment

_____ (initial) I do hereby seek and consent to take part in treatment at TeamBuilders. I understand that although behavioral health sessions may be intimate emotionally and psychologically, our relationship is, and shall remain, of a professional nature, not a personal nature. I agree to play an active role throughout my treatment process or the treatment process of my child, if applicable. I understand that no promises have been made to me as to the results of the treatment procedures prescribed or provided at TeamBuilders. I agree that this authorization will be valid until rescinded in writing or superseded.

Telehealth Consent

_____ (initial) I give my consent to participate and receive behavioral health services via telehealth. The purpose of telehealth is to provide behavioral health care, wellness, coaching, psychoeducational and support services over distance using video-conferencing technology. I understand that my or my child's telehealth provider will communicate with me, my child (if appropriate), or other health practitioners virtually (televideo, email, chat) and telephonically. I further understand that I can request that telehealth be discontinued at any time.

_____ (initial) I understand that there are potential benefits and risks of videoconferencing (e.g., limits to patient confidentiality) and virtual sessions that differ from in-person sessions. I understand that confidentiality still applies for virtual services, and TeamBuilders will not record sessions without specific permission from me and other participants. I agree to use the video-conferencing platform selected for our virtual sessions and was informed on how to use it.

_____ (initial) I understand and agree to the following guidelines for participation in telehealth sessions:

- I or my child will use a webcam or smartphone during video-conferencing sessions.
- I or my child will be in a quiet, private space that is free of distractions (including use of cell phone or other devices) during telehealth sessions.
- I or my child understand use of a secure internet connection rather than public/free Wifi is strongly recommended.
- I or my child will develop a *back-up plan* (e.g., phone number where I can be reached) with my telehealth provider to restart or reschedule the session in the event technical problems arise.
- I or my child acknowledge that TeamBuilders does not provide crisis response unless it is clearly indicated in my service plan. Therefore, I will develop a *safety plan* to use in the event of a crisis that includes at least one emergency contact and the closest ER to my location.

- TeamBuilders has the authority to determine, under certain circumstances, whether telehealth continues to be an appropriate service delivery method for my health care needs.

Artwork, Digital Art, Slides, or Photographs of Artwork in Creative Therapies

Art therapy is a mental health profession in which clients, facilitated by the art therapist, use art and digital media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem. A goal in art therapy is to improve or restore a client's functioning and his or her sense of personal well-being. Art therapy practice requires knowledge of visual art (drawing, painting, sculpture, and other art forms) and the creative process, as well as of human development, psychological, and counseling theories and techniques (American Art Therapy Association, 2013).

_____ (initial) I understand that I or my dependent/child may receive treatment from a trained art therapist and mental health counselor who uses both modalities in treatment to best meet my or my dependent/child's needs. As a result of a course of treatment I or my dependent/child will create artwork, or representations of artwork, which may be considered a part of the clinical record retained by the therapist and/or TeamBuilders.

_____ (initial) I or my dependent/child give TeamBuilders permission to retain actual artwork, photographs, or digital representations of my or my dependent/child's artwork. I have a right to request that artwork be released to me during the course of therapy and at termination in accordance with therapeutic objectives and therapeutic benefit.

_____ (initial) I give my consent for TeamBuilders to keep my or my dependent/child's artwork, copies, slides, or photographs of artwork, for education, research, or assessment purposes. TeamBuilders will not make or permit any public use or reproduction of client art therapy sessions, including dialogue and artwork, without my knowledge.

_____ (initial) I give my consent to use my or my dependent/child's clinical materials and artwork in any clinical supervision, training, teaching, writing, and public presentations. TeamBuilders will take reasonable steps to protect my or my dependent/child's identity and to disguise any part of the artwork or videotape that reveals my or my dependent/child's identity.

_____ (initial) I acknowledge that exhibiting artwork created in art therapy provides an opportunity for me or my dependent/child to show their artwork to the general public or agencies involved in treatment who would not normally see my or my dependent/child's artwork. In preparation for an exhibition of my or my dependent/child's artwork, the art therapist will discuss and weigh the benefits of exhibiting against the potential unintended consequences for me or my dependent/child. I or my dependent/child have the right to refuse to exhibit any or all of my or their creative artwork.

After-Hours Coverage

_____ (initial) TeamBuilders' hours of operation are 8:00 a.m. to 5:00 p.m. Monday thru Friday unless otherwise set by your care provider. All telephone calls made to TeamBuilders before 8:00 a.m. and after 5:00 p.m. are responded to by a nonaffiliated answering service. Messages may be left with the answering service and will be addressed the following business day. For all EMERGENCIES, dial 911 for immediate assistance.

Attendance Policy

_____ (initial) I or my child agree to attend appointments as scheduled or provide notice at least 24 hours from time of appointment if I cannot attend. I understand that attendance is important and that my care provider may terminate services if I repeatedly fail to attend or to make contact with TeamBuilders. I understand that I may be subject to the following fees: Late Cancellations $50.00 and No Show $50.00. These fees are NOT applicable to Medicaid eligible clients.

Termination of Services

Your care provider may also terminate your treatment if there is a history (3 or more) of cancelled or rescheduled appointments or noncompliance.

_____ (initial) I am aware that I may stop my or my child's treatment at any time. However, I will still be responsible for my share of the costs for the services I have already received. I also understand that terminating services may affect treatment outcomes, and/or may result in other consequences. For example, if my treatment has been court-ordered, I will have to answer to the court.

Notice of Privacy Practices

_____ (initial) I acknowledge that I received a copy of the TeamBuilders Notice of Privacy Practices effective January 1, 2022. I was given an opportunity to ask questions at the address or phone number listed on the Notice of Privacy Practice.

Client Rights and Grievances

_____ (initial) I acknowledge that I have received a copy of the TeamBuilders Client Rights and Grievance Form. These rights include the right to privacy of my medical records and confidentiality related to information about my treatment. If at any time I am dissatisfied with services or actions of TeamBuilders I understand that I may let the staff know immediately so that we may work to resolve any concerns. If we are unable to resolve these concerns, I may report complaints to the appropriate licensing or regulatory board.

Primary Care Physician Notification

_____ (initial) TeamBuilders is required to coordinate care with your or your child's primary care physician. Please indicate and initial whether you agree or do not agree to authorize TeamBuilders to release information regarding treatment for coordination of care.

□ I AGREE TO AUTHORIZE □ I DO NOT AGREE TO AUTHORIZE

Appointment Reminders and Messages

I authorize TeamBuilders Behavioral Health to leave a voice message and/or text message about my financial, scheduling, and/or health information at: □ Home □ Mobile □ Work □ Email

Payment/Billing Information

_____ (initial) Please see the fee schedule for information regarding fees. If applicable, your insurance will be billed for services provided. Some insurance companies cover behavioral health services, while others may not. Most do not reimburse for missed appointments, consultation, court appearances, or report writing. Many have deductibles, or only cover a percentage of our fees.

Cost sharing amounts are due at the time of service, or immediately on receipt of a billing statement. Cash, credit card, money order or cashier check are acceptable forms of payment. TeamBuilders does not accept personal checks and cash payment in the exact amount due is needed. In the event that you will not be able to keep an appointment, you must notify TeamBuilders 24 hours in advance, or you may be responsible for paying for the session that you missed. Medicaid eligible clients cannot be billed for late cancellations or no-shows.

Assignment of Benefits/Payment Guarantee

_____ (initial) I agree to the information I have read and hereby authorize and instruct all third party payers who are under contract to the client or to a family member or employer of the client to pay directly and solely to TeamBuilders all benefits that may be due or may become due for services rendered to the client. I hereby assign and transfer to TeamBuilders all benefits up to the amount of actual charges for services. I assume full responsibility for providing insurance cards prior to services rendered. I assume full responsibility as a client, parent, legal guardian or agent to notify the staff of TeamBuilders of any and all recent health insurance carrier changes, updated insurance cards and health insurance plans, and any cancellation of insurance plans which may occur during the time in which services are provided by TeamBuilders.

Statement of Financial Responsibility

_____ (initial) I agree to assume full responsibility for payment of all charges and expenses to TeamBuilders for services rendered or furnished to the client not paid through benefits of prepaid health care insurance plans or other third-party payor to which the client is entitled. I do understand that I am responsible for co-insurance, co-pays or deductibles which may need to be met prior to prepaid health care insurance plans for payment of all services rendered. For any out-of-network services, I also understand that I will be responsible for any unpaid balance which has not been paid by my insurance that is over 90 days old.

I understand that it is my responsibility to provide TeamBuilders with my current address and contact information for coordination of care and billing purposes. I also understand that I am subject to a **$75.00** collection fee for any charges older than 90 days from date of service sent to a collections agent and may be reported to the credit bureau.

In signing below, you are indicating that you have read and understand this informed consent and agree to its terms. You are also indicating that any questions you have had about this statement have been answered to your satisfaction.

In signing below, I acknowledge that I have read, understood, and was provided an opportunity to ask questions about the authorizations provided in this Informed Consent for Treatment and I received sufficient information in response to my questions.

Client Signature (*required* 14 years and older)	Printed Name	Date
Parent/Legal Guardian Signature	Printed Name	Date