El Paso, TX 79930
Phone: 915-490-3116
Fax: 915-288-2681

Desert Star Behavioral Health, LLC

Demographic Information

CLIENT INFORMATION

Last Name , First Name, Middle Name		Date of Birth
Street Address City State Zip Code		E-Mail Address
Employer Name/ School Name		Cell Phone Number
Social Security Number	Sex ☐Male ☐Female	Relationship Status ☐Single ☐Married ☐Separated ☐Divorced ☐ Widowed
Annual Household Income	Number of people living in household	Race/Ethnicity:_____ African American / Asian American / Native AmericanLatino/a Pacific Islander / White (Non-Latino) Other:

GUARDIAN (If under 18 years old or older than 18 with a LAR/Guardian)

Last Name First Name Middle Name		Date of Birth
Residential Address City State Zip Code		E-Mail Address
Employer Name/School Name		Cell Phone Number Work Phone Number

EMERGENCY CONTACT

Name	Relationship	Phone Number

INSURANCE INFORMATION

☐Cash/Private Pay ☐Insurance ☐Medicare/Medicaid ☐Sliding Scale ☐Other: _____				
Insurance Company Name Address City State Zip Code				Phone Number
Name of Insured		Relationship to Client ☐Self ☐Parent ☐Spouse Other:_____	Date of Birth	Social Security Number
Policy/Group No:	ID Number:	Authorization Number:	Co-Pay Amount	Deductible:

CLIENT SERVICES INFORMATION

Any current mental health services being rendered anywhere else?
Diagnosis history:
Any recent psychiatric hospitalizations? If yes, where and last admission date
Language Preference:
Any arrests in the last 30 days?

MILITARY AFFILIATION (for the purpose of collecting data please mark all that apply)

- ☐ Parent/Guardian is a current member of the **active duty** U.S. Armed Forces/ National Guard
- ☐ I am a current member of the **active duty** U.S. Armed Forces/National Guard
- ☐ Parent/Guardian is a current member of the **reserves** U.S. Armed Forces/National Guard
- ☐ I am a current member of the **reserves** U.S. Armed Forces/National Guard
- ☐ **Veteran Retired** Military Affiliated: ( ) Client ( ) Parent/Legal Guardian
- ☐ No military affiliation
- ☐ No response/ Refuse to state

I, _____ (Individual/Guardian), do hereby attest that I understand and agree with all of these statements. That I have had this form explained to me and fully understand its contents including the risks and benefits of the procedure(s). I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

My signature below shows that I understand and agree with all of these statements.

Your signature below indicates that you have read and understand this information and give permission to Desert Star Behavioral Health, LLC to provide behavioral health services via telehealth and that this contract is binding for all future sessions you may have with this clinic.

_____	_____
Signature of Individual (Legal Guardian)	Relationship to individual
_____	_____
Printed Name	Date

Verification And Attestation Under Oath:

By signing below and submitting this Form, I hereby swear under penalty of perjury that I am the person identified above and the information provided in this Form is true and correct.

I have discussed the issues above with the individual/ legal guardian. My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

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Desert Star Behavioral Health, LLC

Consent to Treatment

You are about to take an important step in your mental wellness plan, and you will be seeing a mental health professional. As your mental health provider, we will be entering into a protected relationship and treatment might involve a multidimensional approach. Mental health treatment is a working cooperative relationship between you and your treatment team. Each member of this cooperative relationship has certain responsibilities. We will contribute our knowledge, expertise, and clinical skills. You, as an individual, have the responsibility to bring an attitude of collaboration and a commitment to the mental health treatment process. It offers benefits of improved interpersonal relationships, stress reduction, and a deeper insight into one's own life, values, goals, and development. While there are no guarantees about the outcome of the treatment, your commitment may increase the likelihood of a satisfactory experience.

I do hereby look for and consent to take part in the treatment at Desert Star Behavioral Health, LLC. I understand that developing a treatment plan with the associate and regularly reviewing our work toward meeting the treatment goals are in my best interest to enable me to continue with normal emotional development. I agree to play an active role in this process. _____ (Initial)

The treatment may include recommendations of therapy, case management and/or medications. This is all part of the service of a mental health provider. _____ (Initial)

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Desert Star Behavioral Health, LLC. _____ (Initial)

I am aware that I may stop my treatment with Desert Star Behavioral Health, LLC at any time. I will still be responsible for paying for the services I have received from the associate. I understand that I may lose other services or may have to deal with other issues if I stop treatment with Desert Star Behavioral Health, LLC. (For example, if my treatment is court-ordered, you will be responsible for providing the court with an update on your decision to terminate treatment). _____ (Initial)

I know that I must call to cancel an appointment at least 24 hours before the time of the set appointment. If I do not cancel or do not show up to the scheduled appointment, a fee of $50.00 will be charged. If I have standing appointments and do not show up for two consecutive sessions my standing appointments will be removed. A courtesy notification will be made in advance to avoid any cancellation fees.
_____ (Initial)

Individuals have confidentiality rights; confidentiality does not apply under certain situations: We are required by law to report any suspicion of child abuse. This includes physical or sexual abuse. Also, we have a duty to protect if we suspect anyone is in danger of killing themselves or has made threats to hurt someone else. Except in these rare situations, your child has the right to keep topics confidential from even his/her guardian. Please respect this confidentiality. Again, if there is any concern of harm, suicide, or other dangerous behavior, we will inform you. If we need or think it is in your best interest to communicate with an outside source, we will request a release of information. To ensure effective treatment care, frequent appointments are encouraged. Unless arranged otherwise, individuals that have not been seen for 3 months will be considered inactive. A new evaluation will be needed for any inactive individual to be seen. _____ (Initial)

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive at Desert Star Behavioral Health, LLC is not made, they may stop my treatment and all services. _____ (Initial)

I am aware that if I try to contact my provider through phone, email, text, or any other form of communication over the Internet, my information may not be completely secure. If my information is intercepted, Desert Star Behavioral Health, LLC is not responsible for the breach of individual's privacy. _____ (Initial)

I understand that Desert Star Behavioral Health, LLC reserves the right to discontinue treatment at any time including, but not limited to, a violation by you of this Consent for Treatment Agreement, a change or reevaluation by Desert Star Behavioral Health, LLC of your mental health needs, Desert Star Behavioral Health, LLC's ability to address those needs, or other circumstances that led Desert Star Behavioral Health, LLC to conclude in its sole and absolute discretion that your mental health needs would be better served at an another entity. Under such circumstances, Desert Star Behavioral Health, LLC will suggest a suitable mental health agency. _____ (Initial)

I, _____ (Individual/Guardian), do hereby attest that I understand and agree with all these statements. That I have had this form explained to me and fully understand its contents including the risks and benefits of the procedure(s). I have been given a chance to ask questions and any questions have been answered to my satisfaction.

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Desert Star Behavioral Health, LLC

Limitations of Confidentiality

The laws of the State of Texas require that most issues discussed during treatment with behavioral health providers are confidential. These laws allow you to have privilege of confidentiality by signing a records release authorization form. There are situations whenyour confidentiality is not guaranteed, the situations include but not limited to the following:

1. Your file can be subpoenaed by the courts.

2. Duty to Warn: Employees are mandated by law to disclose pertinent information discussed in treatment if the individual has an intent or plan to harm self or another person. We must inform the proper authorities and notify legal authorities.

3. Vulnerable Adults and Children: Mental health professionals are required by law to report said or suspected abuse of a child or vulnerable adult to the proper social service agencies and/or legal authorities.

4. Employees may consult with another colleague about your case, every attempt is made to ensure identity is still anonymous. In addition, the consulted colleague is held to the same limits of confidentiality.

5. Minors/Guardianship: Parents or legal guardians have the right to access a minor's health information. To work most effectively with a minor, we ask that the parent(s)/Guardian allow us to determine what we will disclose to them. If agreed, we will then inform your parent(s) only of any life-threatening activity.

6. Insurance Providers: Information requested includes a description of impairments, dates and times of service, diagnosis, treatment plans, treatment progress, and prognosis for improvement, case notes and summaries, and any medical document.

7. Prenatal Exposure to Controlled Substances: in keeping with protecting vulnerable populations, Mental Health Providers must report the admitted use of controlled substances during pregnancy that is potentially harmful to the fetus.

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Desert Star Behavioral Health, LLC

Court Presence Policy

If during treatment, the staff must appear in court on the individual's behalf, the following arrangements will be necessary:

A minimum charge of $500 must be paid up-front, prior to the staff's appearance in court. This covers three hours of the staff's time. Even though the staff may not appear in court for the entire three hours or may not be called to testify in that three-hourperiod, this charge covers the time that might otherwise be used to see other individuals during that time. It also covers the basic preparation necessary for the court appearance. Initial_____

Any added time needed in court by the staff will be billed at $150 per hour to the party requiring the staff's presence in court. Any partial time will be rounded tothe next hour (e.g., 3 hours and twenty minutes will be billed as 4 hours). Initial_____

Depending upon the complexity of the case, added time for preparation and research may be necessary. This time will also be billed at the $150 per hour court rate. The need and nature of the research will be discussed in detail with the individual and will be summarized in the bill. Initial_____

Insurance does not cover the cost of court appearances.

The staff requires at least 10 business days to prepare for a court appearance, both in termsof preparing for appearance and to reschedule individuals.

I understand this policy and will abide by its terms.

I, _____ (Individual/Guardian), do hereby attest that I understand and agree with all these statements. That I have had this form explained to me and fully understand its contents including the risks and benefits of the procedure(s). I have been given many opportunities to ask questions and that any questions have been answered to my satisfaction.

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Desert Star Behavioral Health, LLC

Client Rights

Clients have the right to be treated with dignity and respect.

Clients have the right to fair treatment regardless of race, religion, gender, ethnicity, age, disability or source of payment.

Clients have the right to have their treatment and other member information kept private.Only by law may records be released without a client's permission.

Clients have the right to easily access care in a prompt fashion.

Clients have the right to know about their treatment choices.

Clients have the right to share in developing their plan of care.

Clients have the right to information in a language they can understand.

Clients have the right to have a clear explanation of their condition.

Clients have the right to have a clear explanation of their treatment options.

Clients have the right to get information about the services of the insurance provider andthe role of the insurance provider in the treatment process.

Clients have the right to know the clinical guidelines used in providing and managing their care.

Clients have the right to information about providers' work history and training.

Clients have the right to provide input on policies and services provided by the insurance provider.

Clients have the right to know about advocacy and community groups and prevention services.

Clients have the right to freely file a complaint, grievance or appeal and to learn how to do so. Complaints may be filed with the following:

Client Right's Contact
Joyce Gonzalez
550 N. Peyton Rd. Ste. 105, El Paso, Texas 79928
(915) 490-3116

Texas Department of State Health Services
PO Box 149347
(Physical address: 1100 W. 49th Street)
Austin, Texas 78756
Toll Free 1-888-963-7111 or 512-776-7111

Clients have the right to know about the laws that relate to their rights and responsibilities.

Clients have the right to know about their rights and responsibilities in the treatment process.

I, _____ (Individual/Guardian), do hereby attest that I understand and agree with all these statements. That I have had this form explained to me and fully understand its contents including the risks and benefits of the procedure(s). I have been given many opportunities to ask questions and that any questions have been answered to my satisfaction.

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Desert Star Behavioral Health, LLC

HIPPA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
*****PLEASE REVIEW IT CAREFULLY*****

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically on paper, or orally, are kept properly confidential. This Act gives you, the patient, significantly new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entitles that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment**: means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment**: means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations**: include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

We may also create and distribute de-identified health information about treatment alternatives or other health-related benefits and services that may be of interest to you.
We may contact you to provide appointment reminder or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person named by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to keep the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of *March 15, 2003,* and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post such notices and you may request a written copy of a revised Notice of Privacy Practices from this office.

Privacy Officer Name/Address:
Joyce Gonzalez
Office: 915/490-3116

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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Desert Star Behavioral Health, LLC

Court Orders/ Child Custody Agreements

Per Section §681.41 of the Texas State Board of Examiners of Professional Counselors Title 22,Texas Administrative Code, we are required to obtain courts orders, child custody agreements, and/or divorce decrees; see below:

(v) Prior to the commencement of counseling services to a minor client who is named in a custody agreement or court order, a licensee must obtain and review a current copy of the custody agreementor court order, as well as any applicable part of the divorce decree. A licensee must maintain these documents in the client's record and abide by the documents at all times. When federal or state statutes provide an exemption to secure consent of a parent or guardian prior to providing services to a minor, a licensee must follow the protocol set forth in such federal or state statutes.

Please answer <u>one</u> of the following questions:

I certify my minor child is not named in any custody agreement or court order. _____ (Initials)

I certify my minor child is named in a custody agreement or court order and have provided true and accurate copies of the orders. _____ (Initials)

I, _____ (Individual/Guardian), do hereby attest that I understand and agree with all these statements. That I have had this form explained to me and fully understand its contents including the risks and benefits of the procedure(s). I have been given many opportunities to ask questions and that any questions have been answered to my satisfaction.

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Desert Star Behavioral Health, LLC

Appointment Cancellation Agreement

We understand things come up if you need to reschedule or cancel any appointments, the office of Desert Star Behavioral Health, LLC requires **24 business hour notification from the date and time of your scheduled appointment.** Please understand that we set aside this time for you, and if you are unable to make it, we will have missed an opportunity to meet with another individual. This policy is in place to give the office enough time to schedule another individual at that time. If you do not cancel within the 24 hours of your appointment **a fee will be charged**. Individuals with Medicaid are not subject to the fee, however after 1 violation of this agreement, services at this clinic may be ended.

It is your responsibility to call the office at 915/490-3116 to cancel.

Copay/deductible/co-insurance/fee due for each session: **$**_____

*Insurance benefits quotes are *not* a guarantee of payment. I understand that the office Desert Star Behavioral Health, LLC will try to bill my insurance, however **if the insurance does not pay, for whatever reason, I am responsible for any remaining balance.** This may include deductibles, copays, or out of pocket expenses.

My signature acknowledges:

- In the case of a Psychiatric Emergency, I will call 911 or go to the nearest hospital.
- 7-day notification is preferred for any prescription renewals.
- I will adhere to the guidelines above to the best of my ability.

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Desert Star Behavioral Health, LLC

Release of Information (ROI)

Desert Star Beahvioral Health, LLC values your privacy and we are commited to fulfilling its practise in a manner that promotes confidentiality while providing high quality care. We want you to know your rights.

1. The person whose information may be used, disclosed, or exchanged is:
Name (Last, First, MI): _____ DOB: _____

2. I, authorize the designated staff at Desert Star Behavioral Health, LLC to (select one):
○ Disclose ○ Use ○ Receive protected health information

3. The information may be disclosed to/exchanged with this Individual and/or Entity specified below:
Name: _____
Phone: _____
Address: _____
City/State/Zip: _____

4. List the information that may be disclosed/exchanged:

I also authorize the disclosure or receipt of my health information regarding (a selection is required to consent or deny the release of the following information):
◉ Yes ○ No Alcohol or Substance Abuse Records
○ Yes ○ No HIV/AIDS Records
○ Yes ○ No Genetic Information (including Genetic Test Results)

5. This information is permitted to be disclosed/exchanged for treatment purposes only.
List the purpose of the disclosure/exchange:
○ At my request

O Legal purposes
O Billing and claims
O Educational purposes
O Treatment/continuity of care
O To verbally disclose the care and treatment I receive
O Other: _____

The persons or organizations receiving any disclosure of this information will be prohibited by law from re-disclosing any information received based upon this consent and will be notified of that fact in every disclosure.

6. Consent:

Effective date: _____
Expires: _____ (within 1 year of effective date unless otherwise specified below)

I understand that this permission may be revoked. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

O I DENY CONSENT (Revoke) Date: _____

7. Is this request for the purpose of processing and submitting records within the next 10 business days?

O Yes, how would you like these records? (Check one) O no
O Emailed/faxed: _____
O Picked up at this location: _____
O Picked up at the Medical Records Office
O By Mail (same as listed above), if mailing address is different indicate address below:
_____
(ALLOW 10 BUSINESS DAYS FOR YOUR REQUEST)

Individual Rights

I am the person or personal representative of the person whose records will be used, disclosed, or exchanged. I give permission to use, disclose, and exchange records as described in this document.

- You may end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization. If you choose not to agree with this request, your benefits or services will not be affected.

I understand that Desert Star Behavioral Health, LLC (DSBH) may share my health information in my files with another medical provider to help with my treatment with that other provider with or without my permission as allowed under federal and state privacy laws (45 CFR 164.506(c)(4), Tex. Health and Safety Code 611.004(a)(7), Tex. Health and Safety Code 81.103(b)(5)).

I understand that I do not have to give consent to share alcohol and/or substance abuse treatment information with my medical provider(s), but by authorizing disclosure on page one (1) of this form, I freely choose to do so. I also understand that I may revoke, at any time, my authorization for the medical provider(s) to have access to alcohol and/or substance abuse treatment information, however, other information regarding my treatment with DSBH may be shared with the medical provider(s) as allowed under HIPAA and any other federal or state privacy laws. My decision to revoke this authorization shall only apply to information which has not already been shared with the medical provider(s).

If there is any information in my medical record regarding current or past alcohol and/or substance abuse treatment, federal law prohibits DSBH from sharing that information without my permission, unless in certain situations such as a medical emergency (42 CFR Part 2). The sharing of this information may be helpful to my medical provider(s) for my treatment.

I understand that my permission to share this information does not automatically mean that I have an alcohol or substance abuse problem, or that I have ever used or abused alcohol or drugs. Even though I may not have information in my medical record related to alcohol and/or substance abuse treatment, my permission to share this information will allow DSBH to share my medical records quicker to my medical provider(s).

If I choose not to give permission to share alcohol and/or substance abuse treatment information, DSBH will still provide my information to my medical provider(s), however, every document in my medical record will have to be reviewed to ensure that the substance and/or substance abuse treatment information is not shared.

I understand that the review of my medical record may require several hours and that an immediate turn-around cannot be guaranteed.

I, _____ (Individual/Guardian), do hereby attest that I understand and agree with all these statements. That I have had this form explained to me and fully understand its contents including the risks and benefits of the procedure(s). I have been given many opportunities to ask questions and that any questions have been answered to my satisfaction.

My signature below shows that I understand and agree with all these statements.

Your signature below shows that you have read and understand this information and give permission to Desert Star Behavioral Health, LLC to provide behavioral health services via telehealth and that this contract is binding for all future sessions you may have with this clinic.

Verification And Attestation Under Oath:
By signing below and sending this Form, I hereby swear under penalty of perjury that I am the person named above and the information provided in this Form is true and correct.

_____	_____
Signature of Individual (Legal Guardian)	Relationship to individual
_____	_____
Printed Name	Date

I have discussed the issues above with the individual/ legal guardian. My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____	_____
Signature and Credentials	Title
_____	_____
Printed Name	Date

El Paso, TX 79930
Phone: 915-490-3116
Fax: 915-288-2681

Desert Star Behavioral Health, LLC

Consent to Psychoactive Medications

Date: _____

Individual Name: _____ DOB: _____

The above named client and legal guardian (if applicable) have received a complete explanation as checked below:

Antidepressants	Antipsychotics	Anxiolytics/Sedatives/Hypnotics
Mood Stabilizers	Stimulants	Beta Blockers
Clozapine	Anticholinergics	Other:

The explanation was given to the client in simple, non-technical language and include:	Indicate by a check mark
1. The nature of his/her mental and physical condition.	☐
2. The expected beneficial effect on his/her condition as a result of treatment with the medication(s).	☐
3. The probable health and mental health consequences of not taking medications, including the occurrence, increase or reoccurrence of symptoms of mental illness.	☐
4. The existence of generally accepting alternative forms of treatment, if any that could reasonably be expected to achieve the same benefits as the medication(s) and why the physician rejects the alternative treatment.	☐
5. A description of the proposed course of treatment with the medication(s).	☐
6. The fact that side effects of varying degrees of severity are a risk of all medication(s).	☐
7. The relevant side effects of the medication(s) being prescribed are explained, including: a. Any side effects which are known to frequently occur in most individuals; b. Any side effects to which the individual may be predisposed; and c. The nature and possible occurrence of the potentially irreversible symptoms of tardive dyskinesia in some individuals taking neuroleptic medications in large dosages and/or over long periods of time.	☐
8. The need to advise staff immediately if any of these side effects occur.	☐
9. An instruction that the individual may withdraw consent at any time without negative actions on the part of the staff	☐
10. A review of the client's rights under the consent to treatment with psychoactive medication rule (TAC: Title 25, Part, 1, Chapter 414, Subchapter I).	☐

11. An offer to answer any questions concerning these statements.	

I have received a complete explanation of the psychoactive medication(s) by means of: (mark the appropriate)

Oral explanation	
Video presentation	
Printed material	
Other:	

Based upon the explanation, I hereby consent to treatment with a specific psychoactive medication or medication group (class) as indicated above. I understand that I may withdraw this consent at any time; however a probate court may decide that I lack the capacity to make the decision(s) weather or not to take consent/take medication(s) and decide that I must continue taking the psychoactive medication prescribed by my physician.

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Desert Star Behavioral Health, LLC

Medication History

We are now able to view medication history from Surescripts and need your consent to view the information. We understand that certain information may not be available or accurate in the report, include information that you may have asked not to be disclosed due to privacy concerns, over-the-counter medications, and low-cost prescriptions, prescriptions paid for by you or non-participating sources, or errors in insurance claim information. Upon review we may verify medication history with you.

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_____ _____
Signature of Individual (Legal Guardian) Relationship to individual

_____ _____

Printed Name Date

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Signature and Credentials	Title
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Desert Star Behavioral Health, LLC

Consent for Telehealth Services

INFORMED CONSENT FOR TELEHEALTH SERVICES

Telehealth involves the use of electronic communications to enable professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, and referral to resources, education, and the transfer of medical and clinical data:

- Medical records
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate security protocols to protect confidentiality and will include measures to safeguard the data and to ensure its integrity against corruption.

EXPECTED BENEFITS

- Improved access to care by enabling an individual to remain at home (or a remote site) while the professional team member provides treatment.
- Efficient evaluation and management.

POSSIBLE RISKS

As with any procedure, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate decision making by the professional team member;
- Delays in treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal information;
- In rare cases, a lack of access to complete records may result in adverse drug interactions or allergic reaction or other judgment error.

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent,

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment,

3. I understand that I have the right to inspect all information obtained and recorded in the course of telehealth interaction, and may receive copies of this information for a reasonable fee,

4. I understand that a variety of alternative methods of treatment may be available to me, and that I may choose one or more of these at any time. (DSBH) has explained the alternatives to my satisfaction,

5. I understand that no results expected can be guaranteed or assured by my provider.

6. I understand that it is my duty to inform (DSBH) of electronic interactions about my care that I may have with other providers.

7. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be in other areas, including out of state.

8. I attest that I am in the state of Texas and will be present in the state of Texas during all telehealth encounters with (DSBH).

9. I understand the potential risks to technology including interruptions, unauthorized access and technical difficulties. I understand my health care provider, or I can discontinue the videoconference consult/visit if it is believed videoconferencing technologies are not adequate for the situation.

10. My provider has explained how the videoconferencing technology will be used to conduct a telehealth session, that unlike a direct patient/provider in person, I will not be in the same room as my health care provider.

11. I understand my healthcare information may be shared with other individuals for purposes of scheduling and billing. Individual's other than my healthcare provider may be present during the session in order to operate videoconferencing equipment. I further understand that I will be informed of their presence, and that such individuals will keep confidentiality on information obtained during the session. Furthermore, I have the right to request the following:
    - Ask non-medical personnel to leave the telehealth examination room; and/or

- Terminate the consultation at any time.

12. I agree certain situations – such as emergencies and crisis -- are inappropriate for audio-/video-/computer- based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis-oriented healthcare facility in my immediate area.

PATIENT CONSENT TO THE USE OF TELEHEALTH

I have read and understand the information provided above regarding telehealth, have discussed it with my physician or a professional team member as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my treatment.

I understand a copy of this form will be available for me to print.

I hereby authorize (DSBH) to use telehealth during my Treatment.

I, _____ (Individual/Guardian), do hereby attest that I understand and agree with all these statements. That I have had this form explained to me and fully understand its contents including the risks and benefits of the procedure(s). I have been given many opportunities to ask questions and that any questions have been answered to my satisfaction.

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Printed Name	Date

El Paso, TX 79930
Phone: 915-490-3116
Fax: 915-288-2681

Desert Star Behavioral Health, LLC

Consent for Communication

INFORMED COMMUNICATION NOTICE

An automated text message will be sent to the phone number you provide for account confirmation and recovery purposes, and as noted in the Consumer Communications Notice. Messaging, data rates, and Texting Terms and Conditions apply.

You will have the opportunity to customize your preferences for some communications, including delivery options, and to update your telephone number and email address, on the appropriate communications preference page(s) for your Service(s). It is your responsibility to provide us with true, accurate, and complete contact information, and to maintain and update promptly any changes. You understand that failing to update your contact information may delay providing you Informational Electronic Communications. You release and hold us harmless from any consequences of your failure to provide us accurate contact information or to update your contact information.
We reserve the right to modify this Notice at any time. The modified Notice will be effective immediately upon posting. Your continued receipt of Informational Electronic Communications and Informational Calls and Texts will constitute your acceptance of the modified Notice.

1. **Informational Electronic Communications**

   We may provide you with Informational Electronic Communications. Informational Electronic Communications include, but are not limited to, information about your insurance plan, programs, or services that are or may be available to you in connection with your treatment, clinic updates, general wellness reminders or information, prescription reminders, appointment reminders, general health information, newsletters, and surveys.
   Any request to opt-out of receiving Informational Electronic Communications will be effective only after we have a reasonable period of time to process your request. Opt-outs may not apply to certain types of communications, such as account status, Online Service updates, or other communications.
   Communications sent electronically may be provided either (1) via email; (2) by access to a website that we will designate in a notice we send to you when the information is available; or (3) by other electronic means. At times, in our sole discretion, we may still send you paper communications in lieu of, or in addition to, sending them electronically.

2. **Informational Calls and Texts**

When you provide us a telephone number, whether landline or mobile, we may contact you, using automated, pre-recorded, or non-automated means, to provide you information about existing benefits, programs, products, services, or tools.

The frequency and content of our text messages will vary by texting program. As part of enrollment, each texting program provides specific information on how to unsubscribe or seek assistance. Our Texting Terms and Conditions, as well as any program specific requirements apply to your interactions with us via text and are incorporated in this Notice by reference.

TEXTING TERMS AND CONDITIONS

These Texting Terms and Conditions apply when you provide prior express consent to receive text messages from Desert Star Behavioral Health, LLC or their affiliates, subsidiaries, agents, contractors, or vendors ("us" or "we" or "our"). Text messaging from us may include one-time or recurring texts related to your insurance, programs, services, and tools, and/or general health information. Text messages will be sent to your mobile number using an automatic dialing system. Message and Data rates may apply. Text messaging may not be available via all carriers. If you no longer want to receive text messages from us, the sole and exclusive remedy is to end enrollment in the specific texting program by notifying us.
Under no circumstances will we be liable for any direct or indirect, incidental, consequential, special, exemplary, or punitive damages arising out of or in connection with use of text messaging whether we have been advised of the possibility of such damages.
We do not guarantee the successful delivery of text messages by your wireless provider. Messages sent by text may not be delivered if the mobile device is not in range of a transmission site, or if sufficient network capacity is not available at a particular time. Even within a coverage area, factors beyond the control of wireless carriers may interfere with message delivery, including the terrain, proximity to buildings, foliage, weather, and the recipient's equipment. We will not be liable for losses or damages arising from (a) non-delivery, delayed delivery, or misdirected delivery of a text message; (b) inaccurate or incomplete content in a text message; or (c) use or reliance on the content of any text message for any purpose.
These Terms and Conditions are governed exclusively by the laws of the State of Texas, without reference to its rules regarding choice of law.

PRIVACY AND SECURITY

Please notify us immediately if your mobile number changes. We are not liable for any communication or transmission of information by text which happens because you did not report that your mobile number changed. Password-protecting mobile device(s) and enabling encryption, if available, is recommended.

Text messages may include protected health information (PHI). Since text messaging is unencrypted, there is a risk that this PHI could be intercepted or viewed by third parties, including others who access your device. When you choose to receive text messages from us, you do so at your own risk.

The use and disclosure of PHI in text messaging may be governed by additional privacy notices, including applicable HIPAA Notice of Privacy Practices.

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