TELEHEALTH ACKNOWLEDGMENT & CONSENT – DURING COVID-19

I understand and agree to receive telemental health services from my therapist. This means that my therapist and I will, through a live interactive video connection, meet for scheduled psychotherapy sessions under the conditions outlined in this document and the Big Bear Behavioral Health Therapy Agreement form.

I understand the potential risks of telemental health, which **may** include the following: 1) the video connection may not work, or it may stop working during a session; 2) the video or audio transmission may not be clear; and 3) I may be asked to go to my therapist's office in person if it is determined that telemental health is not an appropriate method of treatment for me.

I recognize the benefits of telemental health, which may include the following: 1) reduced cost and time commitment for treatment due to the elimination of travel; 2) ability to receive services near my home or from my home; and 3) access to services that are not available in my geographic area.

I give my consent to engage in psychotherapy via _____ videoconferencing AND/OR _____ telephone. I understand that my therapist will make all efforts to use a HIPAA-compliant technology to transmit and receive video and audio and stores all notes and information related to my treatment in a manner that is compliant with state and federal laws. I also understand that, due to COVID-19, some video platforms and all telephone platforms are not HIPAA compliant. I understand that it is my responsibility to ensure that my physical location during videoconferencing is free of other people to ensure my confidentiality. Furthermore, I understand that recording my sessions is prohibited.

I understand that I have the option to request in-person treatment at any time, and my therapist will assist in scheduling this or make a referral if travel to the therapist's office is not feasible for me. I understand that closer providers may not be available depending on my location.

I understand the limitations to confidentiality with my therapist include reasonable belief that I am a danger to myself or others. I understand that, if my therapist reasonably believes that I plan to harm myself or someone else, my therapist will contact local emergency services to come to my location and ensure my safety.

My signature indicates that I agree to participate in telemental health under the conditions described in this document.

**NOTE, DUE TO COVID-19, THE OPTIONS FOR HIPAA COMPLIANT SYSTMES MAY BE LIMITED. CLINCIANS

Client Name (please print): _____

Legal Guardian (if applicable): _____ Relationship to Client: _____

Client/Guardian Signature: _____ Date: _____

2700 Westhall Lane Suite 207 Maitland, FL 32751
(o)800-840-2528 (f) 407-540-9552

BIG BEAR INTAKE PACKET

Client Name: _____

DEMOGRAPHIC FORM

(Please Print)

Today's date:	Client Number:

CLIENT INFORMATION

Client's last name: [*client name*]	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Dr. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Primary Language	Race:	Ethnicity	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home phone no.: ( )	Cell phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer / School:	Highest Grade completed:

Chose clinic because/Referred to agency by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Reason for Referral?

ADDITIONAL INFORMATION

Legal Guardian Name:	Relationship to client:	Address (if different):	phone no.: ( )
	DCF involvement? ❑ Yes ❑ No	Caseworker Name:	Caseworker phone no.: ( )
Any pets in the home? ❑ No ❑ Yes: _____	Legal Involvement? ❑ Yes ❑ No	Probation officer Name:	Probation phone no.: ( )

Any other current or recent providers for Mental Health, Behavioral Health, or Substance Treatment?

IN CASE OF EMERGENCY

Name of Local Friend or Relative you'd like us to contact in case of emergency:	Relationship to client:	Home phone no.: ( )	Work phone no.: ( )

FINANCIAL AGREEMENT

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the agency. I understand that I am financially responsible for, and agree to pay, any balance or co-payments on my account. I also authorize Psychamerica Behavioral Services LLC/Big Bear Behavioral Health Inc or my insurance company to release any information required to process my claims. If I lose, or choose not to use my insurance, my Self-Pay rate for individual therapy is $_____ per hour, due at time of service. If I choose to self pay, a further breakdown of fees for services will be made available.

Client (Print)	**(Sign)**	**Date**
Guardian (Print)	**(Sign)**	**Date**
Guardian (Print)	**(Sign)**	**Date**
Witness (Print)	(Sign)	Date

Client Name: _____

CONSENT & AGREEMENT FOR SERVICES

AUTHORITY TO CONSENT: I certify that I have the legal authority to consent to treatment, medication, release of information, and all legal issues involving the above-named client. If my status as legal guardian should change, I will Immediately notify the agency of the name, address, and telephone number of the person who has assumed guardianship of the above-named client. I consent for the above-named client to participate in mental health assessment, treatment through Big Bear Behavioral. I understand that I may revoke consent for the above at any time; however, I cannot revoke consent for action that has already been taken.

For guardians other than biological or Adoptive parents:

My relationship to client is:_____ **AND** I have provided the following legally binding documentation to demonstrate authority to consent:

_____ Notarized Power of Attorney _____ Shelter Order _____ Other: _____

ATTENDANCE / EMERGENCIES:

I agree to notify my assigned clinician at least 24 hours in advance if I will not be able to keep my scheduled appointment (leave a voicemail, text message, or send an e-mail). I understand my clinician may close my case if I have 3+ no-shows/ cancellations within a two-month period.

I understand that in case of mental health emergencies, I must call 911 or another appropriate source. I understand that my clinician might not be available at the time of an emergency. If an emergency occurs, after calling 911 or the appropriate phone number, I will notify my clinician alerting him/her of the situation. I understand that a list of emergency phone numbers and community resource phone numbers can be found online at www.bigbearcounseling.org / I understand that I was given a handbook with emergency phone numbers I may use.

CONSENT LOCATION - I authorize and give consent for the above named individual to participate in mental health and behavioral health services and treatment through Psychamerica/Big Bear at the following locations:

_____ Home _____ School: _____ _____Other: _____

I understand that receiving services at school requires information to be shared with the school staff (as indicated on Release of Information for the school), and the security and confidentiality concerns inherent in school based services have been explained to me.

DISCHARGE/AFTERCARE PLAN – If you ever unexpectedly lose funding, I elect the following:

[__] Pay for services on my own, day of service at the Self-Pay Rate.
[__] Have my case closed and receive referrals for alternative community resources
[__] Place services on hold for a month while I contact my insurance company to have funding reinstated

Client Handbook– I have been provided a copy of the Big Bear Behavioral Health, Inc **client handbook**, and each section has been explained to me to my satisfaction; including but not limited to Rights & Responsibilities, Privacy & Practices, Confidentiality, and the Grievance Procedure.

By Signing below, I acknowledge: that the information on this page has been explained to me. I understand that I may revoke consent for the above at any time, however, I cannot revoke consent for action that has already been taken.

[_____] NON-ENGLISH SPEAKING CLIENT – The contents of this page have been explained to me in my native language
[_____] CLIENTE QUE NO HABLA INGLÉS - El contenido de esta página ha sido explicado en mi idioma natal
[_____] NON-ENGLISH PALE KLIYAN - Yo eksplike mouin sa ki nan paj sa nan Lang natif natal mwen

THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED.
A copy of this form shall be considered equally as valid as the original.

Client (Print)	**(Sign)**	**Date**
Guardian (Print)	**(Sign)**	**Date**
Guardian (Print)	**(Sign)**	**Date**
Witness (Print)	(Sign)	Date

Client Name: _____

MEDICATION QUESTIONAIRRE

List any **prescription medication**, including birth control, which you (or the client) are currently taking:

Medication	Purpose	Dose & Frequency	Prescribing Doctor

I decline to answer. I understand knowledge of the medications I take may be an important part of my treatment with a therapist and/or psychiatrist.

Initial : _____

By initialing here, I am attesting that client does not report taking any medications on a regular basis

Initial : _____

Client (Print)	**(Sign)**	**Date**
Guardian (Print)	**(Sign)**	**Date**
Guardian (Print)	**(Sign)**	**Date**
Witness (Print)	(Sign)	Date

Client Name: _____

CORDINATION OF CARE

Client DOB _____ / _____ / _____

I have authorized Psychamerica/Big Bear Behavioral to use and/or disclose certain protected health information (PHI) with my/My child's Primary Care Physician for the coordination of care.

TO PRIMARY CARE PHYSICIAN For *coordination of care.*

_____

(name of doctor or group)

Phone (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Address _____

Suite # _____ City _____

State _____ Zip Code _____

[___] Client reports no PCP.
Big Bear recommends finding a regular PCP

(to be completed by Big Bear after diagnosis)
CLIENT IS RECEIVING BEHAVIORAL HEALTH / MENTAL HEALTH SERVICES FOR OUR AGENCY.

CLIENT IS BEING TREATED FOR THE FOLLOWING DIAGNOSIS:

_____ _____
DSM 5 code Name

And is receiving:

_____ Individual/Family Counseling
_____ Psychiatric Services
_____ Mental Health Targeted Case Management
_____ Group Counseling
_____ Psychosocial Rehabilitation

*** PRIMARY CARE PHYSICIAN ***

_____ please send medical records regarding the following medical condition: _____

If there is any medical problem or concern that we should be aware of, that would be related or interfere with the above diagnosis, please explain below. You can fax this form back to us.

_____
_____
_____
_____

I understand that only the above-specified information can be disclosed by the above-specified organization. This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient [52 FR 21809, 1987; 52 FR 41997, Nov. 2, 1987] - This consent or authorization for release of information shall be effective the date of signature and shall expire one year from the date of signature below or at the time services are concluded if before one year. I also understand that I may revoke this consent or authorization at any time, providing I notify the program in writing to this effect. Revocation has no effect on action previously taken. A copy or electronic copy of this document shall be as valid as the original. I give permission to fax this form to my primary care provider as listed above.

SELECT ONLY IF YOU DO NOT GIVE PERMISSION TO COORDINATE CARE WITH PCP

[___] I choose not to give authorization for coordination of care at this time.

Client (Print)	**(Sign)**	**Date**
Guardian (Print)	**(Sign)**	**Date**
Guardian (Print)	**(Sign)**	**Date**
Witness (Print)	(Sign)	Date

Client Name:

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client's Name: _____ DOB:_____

_____

***** COMPLETE ONE (1) FORM per entity with whom you give permission for Big Bear to share information*****

I authorize Psychamerica/Big Bear to discuss details of my case and/or to disclose certain protected health information (PHI) to the individual or agency listed below. I understand the information shared is for coordination of care and will be on a need-to-know basis, and that my confidentiality of specific session details is still protected except in situations that require legal notification of other agencies, such as in cases of abuse.

RELEASE AND RECEIVE INFORMATION WITH:

*(name of agency/physician/person)*_____

Fax _____ Phone _____

Address: _____ Suite # _____

City _____ State _____ Zip Code _____

Requested Delivery Method:

[___] Fax [____]Mail [____]Phone [____]E-mail [____]Face to Face [____] Other

Purpose:

[___] At the request of the client/ guardian [____] Treatment / Service Coordination

[___] Disability Application [____] Other:_____

I authorize to release:

_____Psychiatric or Psychosocial Evaluations _____Summary of Progress Notes

_____Mental Health Records _____Educational Records

_____Substance Abuse Records _____Physical Health Records/Summary

_____Medications & Dosages _____Other:

Other Instructions: (note: Florida law requires a court order to prevent information release to biological parents or other identified legal guardians):

I understand that only the above-specified information can be disclosed by the above-specified organization. This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient [52 FR 21809, 1987; 52 FR 41997, Nov. 2, 1987] - This consent or authorization for release of information shall be effective the date of signature and shall expire one year from the date of signature below or at the time services are concluded if before one year. I also understand that I may revoke this consent or authorization at any time, providing I notify the program in writing to this effect. Revocation has no effect on action previously taken. A copy or electronic copy of this document shall be as valid as the original.

Unless I provide other instructions IN WRITING,
This authorization expires 1 (one) year from the date signed, or on ___/____/_____

Please submit this request to us in person or: **Fax – 407-540-9552 or E-mail - Records@BigBearCounseling.org**

Or Mail: ***BIG BEAR BEHAVIORAL HEALTH INC, 1009 Maitland Center Commons Blvd, #212, Maitland, FL 32751***

Client (Print)	**(Sign)**	**Date**
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Guardian (Print)	**(Sign)**	**Date**
Witness (Print)	(Sign)	Date