Form 501

East Central Oklahoma Family Health Center
Behavioral Health Consent

Patient Name: ______________________________ Date of Birth: ____________________

I hereby request and authorize East Central Oklahoma Family Health Center (ECOFHC) to provide mental health and/or substance abuse treatment, diagnosis, and/or prevention services to me and/or my minor child (named above).

Confidentiality Statement
I understand that my counselor/therapist will protect my privacy and the confidentiality of my records to the full extent provided by law. I understand that no information about me will be released or disclosed to others outside of ECOFHC without my explicit written consent on a release of information form or as otherwise provided by law. I have read and understand the ECO notice of privacy practices. Conditions under which confidential information may be disclosed without my consent include, but are not limited to:

1. Mandatory reporting of child abuse or elder abuse
2. If I am believed to present a risk of serious harm to myself or someone else
3. Reporting of crimes committed on the premises or against staff or other clients
4. In response to a specific court order
5. In the event of an emergency
6. Billing and provision of supporting documentation to insurance or other third-party payers
7. Audits by accrediting organizations or agencies
8. In response to a related law suit or complaint to a licensing or accrediting organization or board
9. Integration of primary care and behavioral health records (electronic)
10. Case staffing, case management, telepsychiatry

In addition, I agree:

1. To honor the confidentiality of staff and other clients
2. That I will not disclose the identity of others I meet in treatment or at the clinic
3. That I will not disclose any information revealed in treatment or at the clinic
4. That violation of confidentiality will constitute grounds for termination of services

I understand and have been explained the following:

1. The potential risks/benefits of counseling services
2. Client rights/responsibilities
3. The assessment, treatment plan and therapeutic process involving appointments, my therapist availability and emergency procedures
4. Informed consent and confidentiality of minor clients (age 17 and under)
5. Social media policy
6. After hours emergencies
7. Court testimony
8. LPC, LADC licensure disclosures

I certify that I have legal standing to authorize these professional services for myself; and/or, that I have legal custody and/or other required legal standing to request and authorize professional mental health and/or substance abuse services for any child named above.

______________________________ ______________________________
Patient's Signature Date

______________________________ ______________________________
Parent/Guardian/Representative Signature Date
(Specify relationship to patient / authority to sign)

______________________________ ______________________________
Signature & Title of ECOFHC Employee Date

Informed Consent for Counseling
ECO Family Health center and the Behavioral Health Department recognizes that it may not be easy to seek help from a mental health professional. It is our hope that you will gain a better understanding of your situation and feelings and will be able to move toward resolving your difficulties. Our goal is to help you move toward greater health and wellbeing by providing counseling services within a biopsychosocial, cognitive-behavioral perspective. Our staff works within the context of each individual's beliefs, and no attempt is made to impose a personal theology. Your therapist is a licensed professional engaged in providing mental health care services to clients directly as an employee of ECO Family Health Center. Licensure contact information is as follows:

Oklahoma Board of Licensed Drug and Alcohol Counselors (LADC licensure board)
101 NE 51st Street
Oklahoma City, OK 73105
Physical address
P.O. Box 54388
Oklahoma City, OK 73154
Mailing address
Telephone: (405) 521-0779
Fax: (405) 521-0291
Website: www.okdrugcounselors.org
Email: cwaite@okdrugcounselors.org

State Board of Behavioral Health Licensure (LPC licensure board)
3815 N. Sante Fe Ste. 110
Oklahoma City, OK 73118
Telephone: (405) 522-3696
www.ok.gov/behavioralhealth

Further or specific licensure information of your therapist is available to you upon request.

Appointments
Appointments and cancellations are made by calling the clinic at which your appointment is scheduled, Monday through Friday between the hours of 8:00 am and 5:00 pm. Please call to cancel or reschedule at least 24 hours in advance, or as soon as possible. Clients who repeatedly miss appointments may be rescheduled as a walk-in appointment and seen accordingly. Your therapist reserves the right to cancel/reschedule your appointment if you show up sick or with minor children that might interfere with the counseling session. The number of sessions needed depends on many factors and will be discussed by the therapist. The length of therapy sessions range depending on several factors but typically last 45-50 minutes. Initial assessments or your first appointment may take a little longer. You may choose to withdraw from treatment at any time, but please first discuss this with your therapist. We will be happy to assist you in finding another provider in your area to meet your needs.
After hours/emergencies: Emergencies are urgent issues requiring immediate action. If you experience an emergency after regular business hours when our offices are closed, please go to the nearest emergency room, call 911, and/or call the National Suicide Prevention Lifeline at 988.

Risks/Benefits and Participation in Therapy
Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and/or helplessness. The process of

psychotherapy often requires discussing the unpleasant aspects of your life. People often learn things about themselves that they don't like. In many instances, growth cannot occur until past issues are processed and confronted, often causing distressing feelings such as sadness and anxiety. However, psychotherapy has been shown to have benefits for those individuals who chose to participate in the therapeutic process. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will need to work on things we discuss outside of scheduled sessions.

Therapeutic Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship.
The therapist cares about helping you but is not in a position to be your friend or to have a social and personal relationship with you. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist. In some cases dual relationships may be unavoidable due to the rural communities in which we work and live. If you have any concerns or questions, please discuss it with your therapist.
This professional relationship extends to social media and internet usage. As of 1/1/2020, it is the policy of ECO Behavioral Health Department staff to not accept friend or contact requests from current or former clients on any social networking site (Facebook, Twitter, etc). It is our belief that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. ECO Family Health Center as an organization, does have social media account(s) which patients may find beneficial offering healthy living examples, links to resources, community health fairs and general information.

Goals, Purposes, and Techniques of Therapy

There may be multiple interventions to effectively treat the problem(s) that brought you in to see us. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting goals of your therapy. As therapy progresses, these may change.

Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without the patient's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: internal case staffing, child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions, law suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose; a negligence suit brought by the client against the therapist; or the filing of a complaint with a licensing board or other state or federal regulatory authority. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing the Receipt form for the Informed Consent and Privacy Practices, you are giving your consent to the therapist to share confidential information with all persons mandated by law, with the agency that referred you, and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services. You are also releasing and holding harmless the therapist from any departure from your right of confidentiality that may result. Duty to Warn: In the event that the therapist reasonably believes that the patient is a danger, physically or emotionally, to themselves or another person, consent is given for

the therapist to warn the person in danger and to contact any person in a position to prevent harm to themselves or another person, including law enforcement and medical personnel. This authorization shall expire upon the termination of therapy. By signing the Informed Consent and Privacy Practices form, you acknowledged that you have the right to revoke this authorization in writing at any time to the extent the therapist has not taken action in reliance on this observation. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the Notice of Privacy Practices. You acknowledge that you have been advised by the therapist of the potential of the re-disclosure of your protected health information by the authorized recipients, and that it will no longer be protected by the federal Privacy Rule. You further acknowledge that the treatment provided to you by the therapist was conditioned on you providing this authorization.

Court

Although it is the goal of the therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. In the event disclosure of your records or the therapist's testimony are requested by court order or required by law, you will be responsible for and shall pay the costs involved in producing the records and the therapist's normal hourly rate of _$120.00_____ for giving that testimony regardless of who requested/subpoenaed/ordered said disclosure. Such payments are to be made at the time prior to the time the services are rendered by the therapist. The therapist may require a deposit for anticipated court appearances and preparation including travel time associated with the subpoena/court order/testimony. ECO Family Health Center Behavioral Health counselors do not offer psychological evaluations or forensic services including but not limited to custody evaluations. In the event your counselor is compelled to disclose information to a trier of fact, he/she may only provide fact witness testimony per the State Board of Behavioral Health licensure Act and Regulations which are available upon request.

Consent to Treatment

By signing the Informed Consent and Privacy Practices Receipt, you voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment, or services at any time. By signing the Informed Consent and Privacy Practices Receipt, you acknowledge that you have both read and understood all the terms and information contained herein. Ample opportunity has been offered for you to ask questions and seek clarification of anything that remains unclear.

Telepsychiatry

You are not required or obligated to be seen by our contract psychiatrist. But, if you chose to be seen by our psychiatrist for medication management, you will be required to attend counseling as well in order to best coordinate and integrate your care here with us. In addition, by signing the consent for treatment you acknowledge and consent to engaging in telepsychiatry at ECO Family Health Services as part of my psychotherapy. I understand that "telepsychiatry" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telepsychiatry may also involve the communication of my mental health and/or medical information, both orally and visually, to other health care practitioners located within scope of my care at ECO.
I understand that scheduling is conducted through ECO and is based on my provider's normal clinic hours. Telepsychiatry appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed by dialing 911,

calling/texting the Suicide Prevention line at 988 or presenting at the nearest emergency room. I understand that telepsychiatry is not a 'stand alone service'. I agree and understand that by participating in ECO's telepsychiatry services, I am also agreeing to attend and participate in therapy, case management, medical and/or other recommended services on my treatment plan. The laws that protect the confidentiality of my medical and behavioral health information also apply to telepsychiatry. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential with the exception of mandatory reporting and permissive exceptions. This is further explained in the Mental Health Informed Consent, which I have signed. The electronic platform utilized in my telepsychiatry is HIPAA compliant to protect my privacy and confidentiality.

I understand that I have the following rights with respect to telepsychiatry:
1. I have the right to withdraw my consent at any time.
2. I understand that there are risks and consequences associated with telepsychiatry including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist/clinical intern, that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my counselor/therapist/clinical intern believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I may be referred to a counselor/therapist who can provide such services.
3. I understand that I may benefit from telemedicine but that results cannot be guaranteed or assured.
4. I understand that I have a right to access my mental health information and copies of medical records in accordance with state and federal law. I have read and understand the information provided above. I have discussed it with my counselor/therapist/clinical intern, and all of my questions have been answered to my satisfaction.

Rights and Responsibilities

- Receive high-quality service
- Be treated with respect and courtesy
- Have your information kept private and confidential except as described in ECO Family Health Center *privacy statement*
- Be listened to and have staff work with you to make a plan to address your concerns and needs
- Receive service in offices that are safe, clean and accessible
- Receive information and support to help you make decisions to improve your situation
- Be served without discrimination
- Discuss your service with staff to identify if it is working for you and express any questions or complaints that you may have
- Request a change of staff member if there is another staff person available who can address your issues and your request is reasonable -- Please be aware that discriminatory requests will not be considered