Blackbird Behavioral Health, PLLC
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Informed Consent for Services

Mental Health Services

Seeking mental health services, a can be a difficult task. I hope to help you navigate whatever circumstance you find the need for help with through an evidence-based approach and supportive environment. My work is based on each individual's beliefs and circumstance, with no attempt to interject my own personal agenda.

Licensed Clinical Social Worker (LCSW)

A licensed clinical social worker is a social worker who is trained in psychotherapy and various mental health interventions. An LSCW deals with a variety of mental health and daily living problems in effort to improve the quality of life and functioning of the individual. An LCSW in Texas has a master's degree and has completed at least 3000 hours of supervised mental health practice and passed a comprehensive exam. A specific code of ethics guides the social worker's core values and professional behavior.

Appointments and Cancellations

Appointments are made by calling 817-694-9662, Monday through Friday between 8:00 AM- and 5:00 PM. Please call or text to cancel at least 24 hours in advance or you will be charged $75 for the appointment. Third party payers will not usually cover or reimburse the fee for a missed appointment. Medicaid recipients will not be charged a fee per the law. Clients who repeatedly miss appointments may be discharged from service. If the client is 10 minutes late to the appointment the session will be rescheduled, and the missed visit fee will apply. The therapist reserves the right to cancel your appointment if you show up sick, under the influence of drugs or alcohol, or with minor children who interfere with the counseling session.

Number and Length of Sessions

The number of sessions is determined by the therapist and based on several factors which will be discussed with you by the therapist.

A typical intake, individual or couples session is 55 minutes.

EAP sessions are between 45 and 55 minutes depending on the benefit.

Relationship

The relationship with your therapist is professional and therapeutic. In order to preserve the integrity of the relationship, no other types of relationships may exist between therapist and client. Personal and/or business relationships undermine the therapeutic relationship. The therapist cares about you but is not in the position to be your friend or any other social relationship. Your therapist will not acknowledge you in

public. This is not to be unkind, but to preserve confidentiality and maintain professional boundaries. Gifts, bartering or trading services is not permitted.

Goals, Purposes and Techniques of Therapy

There may be various treatments utilized to address the problem you are experiencing. Ask your therapist any questions you have about the recommended treatment. You will have an opportunity to provide input into the type of treatment you receive, however, understand the therapist uses clinical judgement in selecting treatment interventions. The therapist will only utilize treatment options in which he or she has the competency to perform. Treatment types and strategies may change as treatment progresses.

Confidentiality

Discussions between client and therapist are confidential. No information is provided to an outside party without written consent from the client unless a court order or subpoena is received. Exceptions to confidentiality include but are not limited to reports of abuse of children, the elderly or disabled, abuse of patients in a mental health facility, sexual relationship with a therapist of whom you were a client, criminal prosecution, child custody disputes, the client presents an imminent danger to self or others, suits of various nature brought on by the client.

If you have questions or concerns about confidentiality, you should bring them to the attention of your therapist for discussion. By signing the Informed Consent for Counseling and Therapy Services you are consenting to the therapist disclosing confidential information when mandated by law, the agency who referred you and the third-party payer (managed care or insurance company) who is responsible for providing coverage and payment for your mental health care needs.

Duty to Warn

In the event the therapist reasonable believes the client 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 someone else, including but not limited to law enforcement and medical personnel. This authorization will expire upon termination of therapy.

By signing the Informed Consent for Counseling and Therapy Services form you acknowledged that you have the right to revoke this authorization in writing at any time to the extent that the therapist has not acted in reliance on this observation. You further acknowledge that if even you revoke this authorization, the use and disclosure of your protected health information could still be permitted by law as described in the Privacy Practices section of this form. You acknowledge that you have been advised by the therapist of the potential of the re-disclosure of your protected health information by authorized recipients and that it will no longer be protected by the federal Privacy Rule. You further acknowledge that the treatment provided to you was conditioned on this authorization.

Risks of Therapy

Therapy is the Greek word for change. Clients often learn things about themselves that they do not like. Therapy can induce feelings of sadness and anxiety. The therapist may reflect observations about the client's ideas, beliefs and behavior that are less than flattering. Change occurs when ideas, beliefs and past issues are confronted and examined and challenged. The success of therapy depends on the efforts of both therapist and client. Ultimately, the client is responsible for lifestyle changes and choices that result from therapy. Clients seeking marital counseling need be aware that one result of therapy could be someone's choice to file for divorce.

Payment for Services

The rate of services are as follows:

55-minute session of individual intake or psychotherapy: $120

90-minute couples' intake: $200

55-minute couples' session: $130

FMLA, Short Term Disability or other paperwork: $25 per set

Records Request: $25

You are responsible for the payment of all charges. If you have insurance a co-payment may apply and is due before each session begins. The co-pay is determined by your insurance plan and may vary from visit to visit. You are responsible for notifying Blackbird Behavioral Health, PLLC of any changes to you insurance immediately. If you fail to notify Blackbird Behavioral Health, PLLC (BBH) of insurance changes you may be billed for charges not covered.

Home Studies and Other Court Related Services:

The rate of service is $65 per hour for an individual biopsychosocial assessment for court purposes. This includes but is not limited to biopsychosocial assessment for purposes of sentence mitigation and compassionate release. A minimum of 12 hours is required to be paid prior to the initiation of services. Service hours include travel, interviewing, collateral phone calls, request and review of records (medical, mental health, etc.), writing, review and editing. If the assessment goes over 12 hours, you will be billed, and the amount must be paid prior to final draft submission. If the assessment takes less than 12 hours, you will be reimbursed for unused hours. Assessments will be provided directly to your attorney. You may request a copy of your record. Record request fees apply.

The rate of service is $1,500 for non-adoption home assessment, additional fees may apply. Service hours include travel, interviewing, collateral phone calls, request and review of records (medical, mental health, etc.), writing, review and editing. If the assessment goes over 15 hours, you will be billed, and the amount must be paid prior to final draft submission. If the assessment takes less than 15 hours, you will be

reimbursed for unused hours. Assessments will be provided directly to your attorney. You may request a copy of your record. Record request fees apply.

Adoption Evaluation and Child Custody Evaluation fees and information can be provided by calling 817-694-9662 or visiting the website.

Court Testimony: $125 per hour, minimum four hours to be paid at least 14 days prior to the hearing.

After Hours Emergencies

If you have a medical or mental health emergency, please dial 911 or go to the nearest emergency room. If you have an urgent issue after hours that cannot wait until the next business day, you may call the main phone number and a therapist will either answer or return your call within an hour.

Therapist's Death or Incapacitation

In the event the therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of client records. By signing the Informed Consent and Privacy Practices receipt, you give your consent to another licensed mental health professional to take possession of your files and records and to provide you with copies upon request, or to deliver them to a therapist of your choice.

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 and 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 care, treatment and 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.

Contact Information

By signing the Informed Consent and Privacy Practices receipt, you are consenting for BBH to communicate with you by mail, e-mail, and phone at the address and phone numbers provided at the initial appointment, and you will immediately advise BBH in the event of a change in contact information. You agree to notify BBH if you need to opt out of any form of communication.

Notice of Blackbird Behavioral Health, PLLC Privacy Practices

This notice tells you how we make use of your health information, how we might disclose your health information to others and how you can get access to the same information. Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand.

We have the legal responsibility under the laws of the United States and the state of Texas to keep your health information private. Part of our responsibility is to give you

this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice. This notice is effective as of December 13, 2021 and will be in effect until we replace it. We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at BBH. These changes could also affect how we protect the privacy of any of your health information we had before the changes. When we make any of these changes, we will also change this notice and give you a copy of the new notice.

You may request a copy of this notice at no charge to you, at any time.

If you have questions or concerns about the material in the document, please ask us for assistance. Here are some examples of how we use and disclose your health information. We may use or disclose your health information…

1. To your physician or other healthcare provider who is treating you.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state or local laws to have lawful access to your records.
4. To receive payment from a third-party payer for services provided to you.
5. To anyone you give written authorization to have your health information. You may revoke this authorization at any time. When you revoke an authorization, it will only affect your health information from that point on.
6. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable or responding, we may use our professional judgement, considering the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In doing so, we will only use or disclose the aspects of your health information that is necessary to respond to an emergency.
7. To the appropriate state agency if we suspect the neglect or abuse of a minor, elderly or adult with a disability. If, in our professional judgement, we believe that a patient is threatening serious harm to another, we are required to take protective action, which may include notifying the police, or seeking the client's hospitalization. If the client threatens to harm him or herself, we may be required to seek hospitalization.

We will not use your health information in any of our center's marketing, development, public relations, or related activities without your written authorization. We cannot use or disclose your health information in any other ways other than those described in this notice unless you give us written permission.

As a client of Blackbird Behavioral Health, PLLC, you have these important rights:

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.

B. You can ask us for photocopies of the information in part “A” above. There will be a $10.00 charge for copies made here at the Center. If you need copies of your health information due to a Third-party request, we will charge a fee of $25.00 for the first 10 pages, then $1.00 for each additional page.

C. You have a right to a copy of this notice at no charge.

D. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if you request that we contact you on an alternative phone number other than your residence, or if your primary language is not spoken at this Center) Your written request must specify the alternative means and location.

E. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.

F. You can make a written request that we amend the information in part “A” above.

G. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.

H. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.

I. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or our Center’s operations. This can go back as far as six years, but not before December 13, 2021.

J. If you request the accounting in “J” above more than once in a 12-month period we may charge you a fee based on our actual costs of tabulating these disclosures.

K. If you feel we have violated your privacy rights you may submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

RECIEPT: Blackbird Behavioral Health, PLLC

I, ___________________________ acknowledge that I have received signed copies of the Informed Consent and Privacy Practices forms from my therapist/my child's therapist on this date ___________________.

If signing for a minor child, please print child's name: ___________________________

Signature of Parent/Guardian _____________________________Date______________

Client Signature: ____ As witnessed by: ______________________________ (Therapist) ___________ (Date)