TRAUMA TREATMENT CENTER
& Research Facility

1316 Jackie Rd., Suite 900 • Rio Rancho, NM 87124 • 505.289.1042 • Fax: 505.466.5895 • www.traumatreatmentcenternm.com

SECOND PARENT CONSENT

Thank you for allowing Trauma Treatment Center to serve you and your family. Before filling out this form, please make sure you read the below guidelines for completing this packet. If any questions arise feel free to call us. We look forward to seeing you!

• Please fill out this form COMPLETELY. If there are spaces which do not need to be filled out because you are unaware of the answer or the question does not pertain to you or your child then please print "N/A" or "Unknown". If any line or space in this packet is left blank, we will give it back to you to complete before the session can take place. Nothing on our forms can be left blank per HIPPA guidelines.

• Please arrive to your first session with this completed packet, as well as with the insurance card of the patient we are seeing and a driver's license. Also please bring any custody, guardianship, or power of attorney paperwork that pertains to the child as we will not be able to see him/her until this paperwork is provided.

Also be aware that all copays are due at time of service.

Parent Consent Policy and Procedures

I have read, understand and been offered a copy of the POLICY STATEMENT. _____
(Please Initial)

I have read, understand and been offered a copy of the CLIENT'S RIGHTS. _____
(Please Initial)

I have read, understand and been offered a copy of the CLIENT'S RESPONSIBILITY. _____
(Please Initial)

I have read, understand and been offered a copy of the BILLING POLICY. _____
(Please Initial)

I have read, understand and been offered a copy of the HIPPA INFORMATION. _____
(Please Initial)

TREATMENT AGREEMENT

We, the parents of_____, are authorizing our child(ren) to participate in therapy through Trauma Treatment Center. We understand that the purpose of this therapy is to provide our child (ren) with a neutral professional with whom they may talk openly about personal difficulties. We understand that in order for a child to benefit from these sessions, they must be private and confidential in order to protect confidentiality we agree to the following rules and expectations:

A) The sessions between our child(ren) and the therapist of Trauma Treatment Center will be confidential under the same rules that apply in adult psychotherapy as described in the *Ethical Standards for Professional Counselors.

B) A release of information to provide treatment by another professional must be signed by both of us, and will be honored by the therapist only if the child(ren)'s confidentiality will be maintained.

C) We understand that the therapist will inform us only of the following in regards to statements made by the child (ren) in times of therapy:

1. Information leading to a suspicion that a child is being abused or neglected, that is resulting from unfit care by a parent or other adult. Such information will be referred to the New Mexico Human Services Department for investigation, as required by law.
2. Information that the child (ren) is/are in danger to themselves or to others.
3. Information revealing when the child (ren) is brought to sessions, and by whom.
4. Information that the child agrees that the therapist should reveal to one or both parents and that the therapist believes is in the child (ren)'s best interest to reveal.

I/We further agree to support the confidentiality of the sessions by not asking the child(ren) about the content of the sessions, and by clarifying to the child(ren) that it is not necessary to reveal such information, in the case that the child(ren) is/are bringing the information up voluntarily. I/We are the custodial parent(s) or legal guardian(s) of the child(ren) entering treatment. I/We understand and have discussed any questions or concerns with the therapist. I/We consent to have my minor child(ren) participate in treatment.

I, (printed names) _____, and I _____, have read and agree to abide by all the standards listed above.

Signed _____ Date _____

Signed _____ Date _____

(Signatures of both parents or legal guardians)

RECORDS REQUEST POLICY

Trauma Treatment Center keeps very brief records, noting only that you have been here, what interventions happened in session, and the topics discussed. You have the right to request that we make a copy of your file available to any other health care provider at your written request. Your records remain in a secure location that cannot be accessed by anyone else.

Does a parent have a right to receive a copy of psychotherapy notes about a child's mental health treatment?

No. The HIPAA Privacy Rule distinguishes between mental health information in a mental health professional's private notes and that contained in the medical record. It does not provide a right of access to psychotherapy notes, which the HIPAA Privacy Rule defines as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record. See 45 CFR 164.501. Psychotherapy notes are primarily for personal use by the treating professional and generally are not disclosed for other purposes. Thus, the HIPAA Privacy Rule includes an exception to an individual's (or personal representative's) right of access for psychotherapy notes. See 45 CFR 164.524(a)(1)(i).

However, parents generally are the personal representatives of their minor child and, as such, are able to receive a copy of their child's mental health information contained in the medical record, including information about diagnosis, symptoms, treatment plans, etc. Further, although the HIPAA Privacy Rule does not provide a right for a patient or personal representative to access psychotherapy notes regarding the patient, HIPAA generally gives providers discretion to disclose the individual's own protected health information (including psychotherapy notes) directly to the individual or the individual's personal representative. As any such disclosure is purely permissive under the HIPAA Privacy Rule, mental health providers should consult applicable State law for any prohibitions or conditions before making such disclosures.

Trauma Treatment Center policy is to not disclose any psychotherapy notes without the express written consent of the client and/or client representative and to that end will only disclose records to other providers for continuity of care. All requests for records must be submitted in writing and will be processed within 30 days of the request. Trauma Treatment Center does charge a fee for all records requested.

Client	Date
Therapist	Date

AUTHORIZATION FOR DISCLOSURE AND COMMUNICATION WITH PRIMARY CARE PROVIDERS

Please read all information and instructions before completing and signing the authorization form.
This form is to provide authorization for the therapist to have open communication with the client's Primary Care Provider regarding appointments and treatment. The information exchanged is for the purpose of:

• Developing and implementing treatment plans. • Provide verification of appointments and health records when requested.
•Communicating clinical information with other relevant healthcare providers.
• Obtaining names and addresses of all relevant healthcare providers involved in the client's care.
• Communicating significant clinical information to other relevant providers.

Patient's Name: (Please Print) _____ **Birthdate:** _____

Are records filed under another name?_____ Phone Number:_____

THERAPIST/PROVIDER RELEASING **INFORMATION:**	INFORMATION TO BE RELEASED **TO**:
Trauma Treatment Center Organization/Person Name	_____ Organization/Person Name
1316 Jackie Rd., Suite 900 Rio Rancho, NM 87124 Street Address City, State, Zip	_____ Street Address City, State, Zip
505.289.1042 505.466.5895 Phone Fax	_____ Phone Fax

TYPE OF INFORMATION TO BE RELEASED:

☐ Complete Mental Health Record (includes: Intake Assessment and Evaluation, Session/Progress Notes, Medication List, Treatment Plans, Group Notes)
☐ Appointment Times Only
☐ My information relating only to the following treatment or condition(s):_____
☐ My information relating only to the following date(s):_____
☐ Other: _____

REASON FOR REQUEST:

☐ Continuing Care ☐ Other (Please Explain):_____

I understand that the information in my record may include detailed information about behavioral health or mental health services, and varied course of treatment. As well as any other information deemed necessary for diagnosis and treatment.

Release Requiring Specific Consent:

My initials and signature below authorize the release of private health care information relating to testing, diagnosis or treatment for:
____HIV/AIDS ____Mental Health ____Sexually Transmitted Diseases ____Alcohol/Drug Abuse ____Reproductive Care (minors only)_____

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of client information to the above named person or organization. You have the right to revoke or cancel this authorization by written or oral communication.

This authorization expires one year from date of signatures
Client Signature: _____Date: _____
Parent or Legal Guardian Signature: _____Date:_____
Relationship to client, if other than client: _____
(You may be required to provide legal documentation as proof)

☐ **REFUSAL TO DISCLOSE**
Client Signature:_____ Date:_____
Parent or Guardian Signature: _____ Date:_____

POLICY STATEMENT

What I Do:

1. Provide counseling for children, adolescents, couples, and families which supports mental health and family dynamics.

2. Recommend books, support groups, classes, and information for parents that may help with custody, visitation, and shared parenting circumstances.

3. For court-ordered clients, record and report the number of sessions attended, session dates, and client's involvement in therapy.

4. Report harm to self or others according to New Mexico Law.

What I Do NOT Do:

1. Mediation

2. Get involved in the legal aspects of court cases or testify in court, except in special circumstances and with specific arrangements between myself and the judicial system.

3. Make recommendations for parenting time, custody or visitation for children in divorce and separation situations.

4. Evaluate a child for possible sexual or physical abuse or neglect.

Cancellation and Missed Appointment Policy:

Trauma Treatment Center has instituted an Appointment Cancellation and Missed Appointment Policy. A cancellation made with less than 24 hour notice significantly limits our ability to make the appointment available for another patient in need. Multiple Cancellations in a month significantly limits our ability to provide adequate treatment to your child/family.

To remain consistent with our mission, we have instituted the following policy:

- Please provide our office a 24 hour notice in the event that you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient. A message can always be left on our voicemail to avoid a cancellation fee being charged.
- A "No-Show", "No-Call" or missed appointment, without proper 24 hour notification, may accrue a $50 fee.
- This is fee is not billable to your insurance.
- After 1 "No-Show" or cancellation within 24 hours, your therapist will be in communication with you that week. After a 2nd no show, or cancellation within 24 hours, you may lose your regularly scheduled appointment time.
- After 2 cancelled appointments within a month you also may lose your regularly scheduled appointment time.
- After 3 "No-show" or cancellations within 24 hours, you will be referred to another mental health provider for services.

If you have any questions regarding this policy, please let our staff know and we will gladly clarify any questions you have. A copy of this policy will be provided to you if need be. Please sign and date below to show your acknowledgement.

I have read and understand the Appointment Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time to time by the clinic.

Printed Name of Patient **Signature of Patient or Guardian**

Date

HIPAA INFORMATION AND CONSENT

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. What this is all about specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

Additional information is available from the US Department of Health and Human Services, www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the clinical director.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

CLIENT RESPONSIBILITIES

1. You are expected to display the same reasonable behavior of any person. In counseling, emotional expressions are appropriate; however, extreme behavior is not. Your behavior may not violate New Mexico State Criminal Statutes, especially as they relate to harm to self or the person or property of others.

2. In order to promote the successful resolution of the reasons you came to counseling, you will in general be expected to work toward mutually agreed upon goals.

3. You are expected to pay the agreed upon rate for services.

4. You are expected to attend your appointments as scheduled, or to give 24-hour notification if an appointment will be missed. Clients who miss appointments or cancel late will be charged for the session and may have their cases closed.

5. It is important to come to counseling sessions with a clear mind. If you are under the influence of any mind-altering chemical, you will be asked to reschedule for another time and will be charged for the session.

6. Clients are expected to arrange for childcare for sessions in order to participate fully in your therapy. Children are very sensitive to emotions and it is not appropriate that they be present for parents' sessions. Also, for liability reasons, children under twelve may not wait in the waiting room unaccompanied. Counselors will need to reschedule appointments if children are brought unsupervised. You will be charged for the session.

CLIENT RIGHTS POLICY

Therapists with Trauma Treatment Center pledge to protect the rights of each individual who is provided counseling services.

You, as my client have the right:

1. To give informed consent.
2. To refuse Treatment.
3. To be advised of the potential consequences of refusing treatment or medication.
4. To actively participate in the development of an individualized treatment plan/goals.
5. To know the qualifications of staff providing treatment.
6. To a grievance procedure.
7. To a humane and safe environment.
8. To be free from abuse, neglect, and exploitation.
9. To dignity.
10. To personal privacy and confidentiality.
11. To free communication within the constraints of the individualized treatment plan.
12. To have the justification for any restrictions on communications documented in the client record.
13. To know the cost of treatment.
14. To know about third party coverage of treatment, including full charge and any available sliding scale program assistance.
15. To be informed as to any limitations of treatment or services for the duration of the treatment.
16. To refuse to participate in research.
17. To not be refused access to services without informed communications from counselor and informed as to reason and duration of this decision.
18. To receive a complete explanation of client rights in clear, non technical terms and in a language the client can understand.
19. To receive treatment that is non-discriminatory based on race, gender, religion, age, disability, or sexual orientation.

BILLING POLICY

You have the right to terminate your child's therapy at any time. If you choose to do so, Trauma Treatment Center will offer to provide you with names of other qualified professionals whose services you might prefer.

We believe the ending of a relationship is as important as the beginning and the middle. When it is time to terminate, we believe it is important to have a final session to review our work together and provide closure for all of us.

In the event, that your therapist would be unable to continue your child's treatment, due to sudden change in life circumstances or death, your child's records will be handled confidentially by a selected mental health colleague and referred to an appropriate provider.

Attendance

1. Attendance is essential to the clinical effectiveness of working with your family. Adherence to all appointments is crucial in order to achieve the goals set forth in the treatment plan.
2. Since the scheduling of an appointment reserves that time specifically for you, a minimum of 24 hours' notice is required for the rescheduling or cancellation of an appointment. Unless special exceptions are made, a $50 fee will be charged for sessions missed without such notification. This does not include those insured by Medicaid.
3. After 3 missed appointments without sufficient notice, I may lose my regularly scheduled time slot or may be referred to another agency for services.

Billing and Statements

Trauma Treatment Center accepts most major insurance and does the billing for you. We use the following codes to bill for the services provided:

90791 – The initial consultation with parents
90832 – A 30 minute therapy session with the patient
90834 – A 45 minute therapy session with the patient
90837 – A 60 minute therapy session with the patient
90846 – A consultation with out the patient present
90847 – A family counseling session
90853 – A session including 2 or more people
90875 – An interactive complexity code
90839 – A patient in an emergency crisis, 60 minutes
90840 – A patient in an emergency crisis, an additional 30 minutes

We ask that a credit card be placed on file so that the copay's and uninsured amounts can be charged to the card in a timely manner. However, we cannot bill your credit card until after we confirmed your deductible has been met and what the insurance company shows as your copay.

Although Trauma Treatment Center makes every attempt to confirm insurance coverage, deductible amounts and copay information, it is your responsibility to know and keep track of your deductible and how much of that you have met along with your copay amounts. You will receive a statement each month with the balance owed on your account and a prompt payment is expected. If your account accrues a past due balance for more than 30 days, services may be suspended until the account is brought current.

Billing questions and payments should be directed to Kate Bunch at 505-908-5795.

PATIENT CREDIT CARD ON FILE AGREEMENT

We have implemented a policy which enables us to maintain your credit card information securely on file. In providing us with your credit card information, you are giving **Trauma Treatment Center,** permission to automatically charge your credit card on file for your co-pay [or any other client(s) you have listed on this form] at the time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Co-Pays: Co-pays are due at the time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other client(s) you have listed on this form] and there is an outstanding balance owed, **Trauma Treatment Center** will notify you via phone, in person, or through a client statement. If by the final billing after discharge notice we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by mail to you at the address we have on file. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I authorize **Trauma Treatment Center** to charge co-pays and outstanding balances on my account to the following credit card:

VISA ☐ Master Card ☐ American Express ☐ Discover ☐ Primary Client Name:_____

Credit Card Holder's Name: _____
Credit Card Number:_____
CVV:_____
Expiration Date:_____
Billing Zip Code_____
Card Holder's Signature: _____ Date: _____

If you wish to leave this credit card on file for other client(s), please print name(s) below:

Client Full Name:_____
Client Full Name:_____
Client Full Name:_____
Client Full Name:_____
Client Full Name:_____

COORDINATION OF BENEFITS

What is Coordination of Benefits?

Coordination of Benefits (COB) is a process where individuals, couples or families who are covered under more than one health plan combine their coverage to maximize their benefits. One plan becomes the primary plan and pays benefits first while the other plan becomes the secondary plan and pays the remaining balance for eligible expenses. It is crucial that a COB is set up to avoid rejected claims, and ultimately, the patient becoming responsible for any and all charges for services. Ultimately, both insurances need to be aware of each other, and need to know who the primary and secondary provider/payer is. You and your insurance companies are responsible for deciding what provider is primary and what provider is secondary.

Examples of COB include:

Children covered under both parents' plan (i.e. Medicaid and another commercial company's health plan)

Children covered under both parents' plan (i.e. A BCBS commercial plan through Mom, and a Pres commercial plan through Dad)

It is our policy to obtain proof of COB before scheduling a potential client with dual insurance coverage. We must be provided a contact name and a reference/ticket # regarding the conversation you've had with BOTH of your insurance providers around setting up a COB, this way we can contact both companies to verify that they know who the primary and secondary payers are, so that in turn, we will have the information needed to properly bill both providers without kickbacks.

If a client at Trauma Treatment Center obtains dual coverage while being seen here, the responsible parties will have 14 days to provide proof of COB between insurances or services may be suspended.

Printed Name of Patient **Signature of Patient or Guardian**

Date

CONSENT FOR EMAIL AND/OR TEXT MESSAGE COMMUNICATION

Email and text messaging allows Trauma Treatment Center health care providers to exchange information efficiently for the benefit of our patients. At the same time, we recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

If you would like us to send you email and/or text messages that contains your health information, please complete and sign this Consent below. You are not required to authorize the use of email and/or text messaging and a decision not to sign this authorization will not affect your health care in any way.

If you prefer not to authorize the use of email and/or text messaging we will continue to use U.S. Mail or telephone to communicate with you.

_____

Signature Date

_____

Name (please print)

_____

Email address and/or text messaging number to which your Trauma Treatment Center provider may send YOU your health information (please print)

_____

Email address and/or text messaging number to which your Trauma Treatment Center provider may send YOUR PERSONAL REPRESENTATIVE your health information (please print).