BOONE COUNTY HEALTH CENTER
BEHAVIORAL HEALTH SERVICES
723 West Fairview Street
P.O. Box 151
Albion, NE 68620

Welcome and thank you for prioritizing your mental health with Boone County Health Center-Behavioral Health Services! Your comfort and privacy is our top priority. Whether you're dealing with anxiety, depression, or other mental health struggles, we're here to help. Your mental health matters, and we're here to take the next step with you.

INFORMED CONSENT:

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual and professional agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss with us or ask questions.

The Therapeutic Process

You have taken a positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. We cannot promise that your behavior, mindset, and/or circumstance (s) will change. We can promise to support you, advocate for you, empower you, and understand your struggles or repeating patterns. We will work together professionally to help you clarify what it is that you want for yourself and improve your emotional wellbeing.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests to have information released and signs said release of information to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to complete suicide or otherwise conducts themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has reason to suspect that a child or vulnerable adult is abused, neglected, or exploited.
4. If a court of law issues a legitimate subpoena for information stated on the subpoena.
5. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

At times, we as clinicians within the Behavioral Health Department may need to consult one another, as professionals in order to provide the best treatment for you. Information about you may be shared in this context and information provided will be minimum necessary for supervisory/consultation purposes.

Primary Care Provider
Often, your primary care provider is the person who referred you for services or provides ongoing medication management. For purposes of collaboration and effective treatment we can send updates, treatment plans, dates of appointments, or consult with our Boone County Health Center providers to assist in any wrap around services (ex. medication management, hospitalization, etc.). Also depending on your pay source, such as with Medicaid, we are required to contact your primary care provider. We want to ensure we are respecting each client's wishes regardless of their medical provider and the confidentiality of your behavioral health records is a top priority for us, therefore, information shared is minimum and only as needed. We will communicate with you as this occurs. Please sign and date attached release of information for your primary care provider. If you do not wish any form of communication with your primary provider, we will have you note your refusal on the release.

Rural Specific Confidentiality
In rural communities, dual relationships are often unavoidable. It is likely you will see your therapist in the community or have to interact with them in another role. We avoid these conflicting relationships as often as possible, however, you are encouraged to discuss any dual relationships with your therapist or request a therapist you have no previous relationship with when scheduling your appointment. Due to the nature of living in a small community, it is likely you and someone you know will have the same therapist. Your therapist will not discuss, confirm, or deny your care or someone else's care unless you have signed a release of information.

If we see each other accidentally outside of the therapy office, we will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to us, and we do not wish to jeopardize your privacy. However, if you acknowledge any one of us first, we will be more than happy to speak briefly with you, but will discourage engagement in any lengthy discussions in public or outside of the therapy office.

INFORMED CONSENT OF A MINOR
We value the privacy of our minor clients similar to that of our adult clients, however due to their minor status, there are differences in their confidentiality and treatment. As the legal guardian of a minor child you have reasonable access to their mental health record and treatment. We ask that you respect the privacy of the minor child, but will always include a legal guardian in our formation of treatment goals and any issues related to safety. Please be prepared to provide documentation of legal custody for the minor seeking mental health treatment. Consent to treat signatures are required on the back page.

EMERGENCY PROCEDURES AND CONTACT INFORMATION
BCHC Behavioral Health is an outpatient office and is not designed to be used in an emergency. **In the event of an emergency call 911** or go to your local emergency department for assistance. For urgent needs you may contact Boone County Health Center Emergency Department at 402-395-2191 or contact your primary care physician. You may also contact our office at 402-395-3247 and leave a message for your therapist. Your therapist or office staff member will return your call as soon as possible during office hours.

BCHC Behavioral Health Office Hours are Monday-Thursday 8:00-5:00, Fridays 8:00-12:00. Please note, we are closed on all major holidays.

Other Mental Health Crisis Resources:
988 Suicide & Crisis Lifeline -Call, Text, or Chat: 988
Crisis Text Line: Text HOME to 741-741

SOCIAL MEDIA POLICY
Ethically, we as Mental Health Practitioners are unable to interact with our clients on social media. We will not accept friend or follow requests from our clients. If we were connected on social media prior to you beginning therapy services, we will unfriend/unfollow you.

FINANCIAL RESPONSIBILITY
Insurance Coverage and Client Responsibility
If you have health insurance, it may pay for part of the cost of therapy. You are responsible for your deductible and co-payment the day of your session unless you have made other arrangements. If you have not met your deductible, you are responsible for the financial cost of your treatment. It is your responsibility to check with your insurance provider regarding your insurance coverage of mental health treatment. Please be prepared to show your insurance card to the receptionist prior to each appointment. It is your responsibility to notify the office of any changes to your insurance coverage.

Billing
Boone County Health Center utilizes Revenue Cycle Specialists (RCS) to complete patient billing. There may be financial assistance available to help you pay your bill through Boone County Health Center and other mental health voucher programs. If you are interested in financial assistance, please discuss this with your therapist. If you have any billing related questions, please contact Boone County Health Center at 402-395-2191 and ask for Patient Services.

Nebraska Rural Response Hotline:
The Nebraska Rural Response Hotline is one of the primary services provided by the Farm Crisis Response Council through Interchurch Ministries of Nebraska. The COMHT (Counseling, Outreach, and Mental Health Therapy) provides a limited amount of no cost vouchers to those in a crisis. Please call them to see if you qualify at 1-800-464-0258.

Fee Schedule
Below is the cost of mental health services.

Initial Interview and Assessment	$265.00
Individual Psychotherapy (30 min)	$155.00
Individual Psychotherapy (45 min)	$205.00
Individual Psychotherapy (60 min)	$280.00
Family Psychotherapy without Patient (50 min)	$200.00
Family Psychotherapy with Patient (50 min)	$215.00
Alcohol and/or Drug Assessment	$300.00

SCHEDULING APPOINTMENTS

Appointment times range from 30-60 minutes but will ordinarily be 45-55 minutes, at a frequency decided between you and your therapist. You can view scheduled appointments in Patient Portal. Patient Portal questions can be addressed by our receptionist, Kim Buck.

No Show Policy

If you need to cancel or reschedule an appointment, we ask you give a minimum 24-hour notice. We understand things come up and emergencies happen. In the case of emergencies or illness, please contact us as soon as possible to cancel or reschedule your appointment. If you do not contact our office and no show your appointment, it may be determined by your therapist to remove any future sessions you have scheduled. Please contact our office or check your Patient Portal after missing a session.

Wait Time/Late to Session

As therapists, we do our best to begin and end sessions on time. Due to the nature of mental health, there are times sessions run late to ensure our clients are safe and regulated.

If you are 15 minutes late to your session it may be determined by your therapist to cancel/reschedule your appointment. Please be on time to your sessions or notify the office if you will be late.

CONSENT FOR TELEHEALTH THERAPY

Due to barriers such as transportation, attending college, childcare, or financial burdens it is sometimes determined between therapist and client they are unable to attend sessions in person. Technology now allows us to do this although there are some limitations and extra precautions to be addressed and agreed upon.

By signing the back page, I agree to the following items:

1. I understand that my therapist may allow us to engage in telehealth sessions as needed or requested by either patient or therapist.
2. I understand how the video conferencing technology will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my therapist.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. This location will be shared with your therapist and must be in the state in which your therapist holds their licensure (Nebraska).
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my therapist or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my therapist, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
6. I understand it is my responsibility to ensure telehealth visits are covered by my insurance policy and I understand if telehealth therapy is not covered, the cost of the session will be my financial responsibility.

Telehealth by Zoom is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use, there are no passwords required and all you need is the link which will be provided by your therapist.

By signing the back-page document, I acknowledge:

1. Telehealth by Zoom is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. For confidentiality reasons, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.
3. Depending on your location, confidentiality cannot be guaranteed as you, the client, will be responsible for finding a private space to attend session.
4. Given the licensure of current clinicians you are required to be located in the state of Nebraska.
5. In the event your telehealth session is disconnected and you or your Emergency Contact Person cannot be reached, your therapist may contact law enforcement to conduct a welfare check.

EMERGENCY PROCEDURES SPECIFIC TO TELEHEALTH THERAPY
(Also utilized for in person services)

There are additional procedures that we need to have in place to provide ethical telehealth services. These are for your safety in case of an emergency and are as follows:

1. You understand if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis we cannot solve remotely, your therapist may determine you need a higher level of care and Telehealth services are not appropriate.
2. We require an Emergency Contact Person (ECP) who may be contacted on your behalf in a life-threatening emergency only. Please provide this person's name and contact information below. In the case of an emergency, either you or your therapist will verify your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or therapist determine emergency care is necessary, your ECP agrees to take you to a hospital.

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PLEASE RETURN THIS PAGE

By signing below, I acknowledge that I have read, understand, and consent to the information provided by Boone County Health Center-Behavioral Health Services including: INFORMED CONSENT, INFORMED CONSENT OF A MINOR, EMERGENCY PROCEDURES, CONTACT INFORMATION, SOCIAL MEDIA POLICY, FINACIAL RESPONISIBLITY, SCHEDULING APPOINTMENTS, CONSENT FOR TELEHEALTH THERAPY, EMERGENCY PROCEDURES SPECIFIC TO TELEHEALTH THERAPY.

_____ _____
Signature of Client (even if minor) Printed Name

_____ _____
Date Client Date of Birth

_____
Signature of legal guardian or power of attorney (if applicable)

_____ _____
Printed Name Date

Emergency Contact Person Name: _____

Emergency Contact Person Phone Number: _____

Primary Care Provider Name: _____

Agency/Contact Information: _____

_____

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****Please complete the attached releases of information for your Emergency Contact Person and PCP including writing "REFUSED" on it if you are declining. If there is any other person who may be involved in the mental health treatment of the minor child (step-parent, grandparent, or other adult support person), please complete additional releases of information for this person.**

Please list the legal guardian(s) of the minor child

Parent/Guardian 1:

_____

Parent/Guardian 1 Contact information:

_____

_____

Parent/Guardian 2:

_____

Parent/Guardian 2 Contact information:

_____

_____