MENTAL HEALTH ACKNOWLEDGMENT AND CONSENT
Counseling New Patient

At the SEL Clinic, we take pride in providing excellent patient care in line with our SEL Values and Principles of Operation. We look forward to serving you!

Acknowledgment of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) requires us to give you a notice of our privacy practices and to acknowledge your receipt of the notice. What is the Notice of Privacy Practices? The Notice of Privacy Practices explains how your protected health information may be used or disclosed by us. In addition, it explains your rights with regard to your protected health information as well as our legal responsibilities. You should review our Notice of Privacy Practices before you sign this Consent. We have the right to revise this Notice at any time. You may request a copy or access a copy of our Privacy Practices on our website at any time.

Confidentiality of Services

All mental health counseling services are required by law to maintain confidentiality. Confidentiality in counseling means that your information can only be released to any party given your written consent. Written consent to release confidential information may be revoked at any point in time. In order to maintain continuity of care in the management of your health, there may be instances where your primary care provider will be notified of therapeutic progress.
Confidentiality cannot be maintained and will be broken under the following circumstances:

1. If you communicate an intent to seriously harm or kill yourself and it is deemed a genuine communication in which there is concern that you would present as a legitimate harm to yourself.

2. If you communicate an intent to seriously harm or kill someone else and it is deemed a genuine communication in which there is concern that you would present as a legitimate harm to that person.

3. If you communicate about known, or suspected, abuse of a child, dependent adult, or someone who is developmentally disabled, it will be reported to the appropriate authorities.

4. If there is a court order for your records that mandates the divulgence of your information.

Consent to Treatment

I, the undersigned, understand that I am willingly enrolling in psychological services. I understand confidentiality and the limitations that may exist. I understand that psychological services can have benefits and risks. The risks may include general discomfort due to discussing negative life events and unpleasant aspects of life. The risks may also include a perceived worsening of physical or mental health. The benefits that may be received from engaging in psychological services may include improved functioning at work and at home, better relationships with others, and reduction of distress.

Signature ______________________________ Date ______________

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Release of Health Information

I, the undersigned, certify that the client is covered by SEL's insurance and is eligible to receive services at the SEL Health Clinic. I also authorize my counselor to disclose my health information necessary to carry out treatment, payment, or healthcare operations. _____(**Initials**)

If the Patient **IS** a Minor:

Other authorized persons that can bring this minor in for medical care include:

Name	Phone	Relationship
______________________	______________________	______________________

I understand I may revoke this authorization and consent in writing, except insofar as health information has been disclosed prior to my revocation. If I do so, I understand the SEL Health Clinic has the right to decline to provide me further medical care.

Reschedule/Cancellation Policy

______(**Initials**) I understand when I make an appointment that time is saved for me with a provider. I will be conscientious of this and will inform the SEL Health Clinic within 24 hours if I am unable to attend my scheduled appointment. After two cancellations without proper notice, all future appointments will be canceled. It is my responsibility to reschedule any canceled appointments.
Late Policy: If late 10 minutes or more, appointments are canceled and may be rescheduled.

Mental Health "No-Show" Policy

______(**Initials**) I understand when I make an appointment for counseling services that time is saved for me with a provider. If I miss an appointment, I understand that 1 attempt will be made to contact me to determine why I missed my appointment. It is my responsibility to inform the Health Clinic of an accurate phone number, and if I cannot be reached or do not respond to an attempt to reach me within 2 business days, ALL future appointments I have with Mental Health will be canceled.

Recording Policy

______(**Initials**) I acknowledge that video, audio, or any other recording methods are prohibited during counseling sessions.

Patient Termination Policy

______(**Initials**) The SEL Health Clinic reserves the right to terminate patient relationships under the following conditions: non-compliance with treatment instructions, repeated canceled appointments, verbal abuse or other inappropriate behavior towards staff or other patients, or other unacceptable conduct or behavior which adversely affects a patient's treatment, the treatment of other patients, or the operations of the SEL Health Clinic

Signature of Acknowledgment of Receipt of Notice of Privacy Practices, General Consent, and Release of Health Information. Please note: In accordance with State laws, parent/guardian permission is not needed for adolescents over the age of 13 being seen for psychological services.

Patient Name (Print) ______________________ Date of Birth (DOB) ______________________

Patient Signature ______________________ Date ______________________

Parent/Guardian Signature ______________________ Date ______________________