New Client Access Application – Adult Mental Health Services

(for Addiction Services, please complete the Substance Use Disorder New Client Application Instead)

WELCOME TO WMMHC!

Thank you for choosing to partner with us in meeting your mental healthcare needs!

This packet can be dropped at the nearest WMMHC office or mailed to 1321 Wyoming Street, Missoula, MT, 59801. The online version is at WMMHC.org > Getting Started > Admission Process.

Name: _____ _____ _____ _____
First Middle Last (Maiden)

Preferred Name: _____ Suffix: _____

Date: _____ Social Security Number: _____

Legal Guardian (if applicable): _____

Birthday: _____ Sex: _____

Gender Identity: _____ Preferred Pronouns: _____

Contact Phone Number*: _____

We will use your Contact Phone Number for Appointment Reminders unless you select otherwise

Mailing address: _____ City_____ State _____
Zip _____

Physical address: _____ City _____ State _____
Zip _____

If homeless, nearest post office to you: (city) _____

Emergency Contact Name: _____ Phone Number: _____

Language preference: _____ Assistance requested: Yes/No

Health Insurance

- ☐ I DO NOT have any health insurance including Medicaid.
- ☐ I would like help signing up for Medicaid.
  If you would like to learn if you are eligible for a discount on your bill, please complete a Sliding Fee Scale application on WMMHC.org > Admission Process > Forms & Policies > Sliding Fee Scale
- ☐ I DO have health insurance coverage. Please complete below.

Policy Holder's Name	Policy Holder's Birthdate	Policy Number (include prefix, if applicable)	Group Number	Insurance Company Name	Who in the household is covered?
Primary:					
Secondary:					

Are you seeking services for (please check all that apply):

- ☐ Mental health therapy
- ☐ Addiction Services, including Recovery Center Missoula or Carole Graham, in addition to Mental Health therapy (Please complete Substance Use Disorder New Client Application as well)
- ☐ Medication Management
- ☐ PACT/MACT
- ☐ Behavioral Health Group Home
- ☐ Court Ordered
- ☐ Other _____

What is your race?

- ☐ White/Caucasian
- ☐ American Indian/Alaskan Native
- ☐ Hispanic
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ More than one race
- ☐ Other

What is your ethnicity?

- ☐ Hispanic: other
- ☐ Hispanic: Mexican
- ☐ Hispanic: Cuban
- ☐ Hispanic: Puerto Rican
- ☐ Non Hispanic

Have you ever served in the military? Yes____ No _____
Do you have an authorization from the VA for the desired services? Yes _____ No _____
Would you like assistance applying for authorization for VA-covered services? Yes ____No ____

What is your marital status?

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Other

What is your sexual orientation? _____

What is your current living situation? (please choose one)

- ☐ Living independently
- ☐ Living with family or friend
- ☐ Homeless
- ☐ Assisted Living
- ☐ Group Home
- ☐ Other _____

Which pharmacy do you use? _____

Do you have a primary care provider? Yes ❑ No ❑
If yes, what is your provider's name? _____
Phone Number: _____
Town: _____
Have you seen your provider in the past year? Yes ❑ No ❑
Do you have other mental health providers? Yes ❑ No ❑
Name: _____
Do you have other healthcare providers? Yes ❑ No ❑
Name: _____
Name: _____
Name: _____
Please include a release of information for each listed provider, if you would please?

Have you ever been told you have any of the following?

- ❑ hypertension
- ❑ lung disease
- ❑ heart disease
- ❑ diabetes
- ❑ cancer

If yes, are you being seen for this condition(s)? Yes ❑ No ❑

WESTERN MONTANA
MENTAL HEALTH CENTER

Consent for Treatment

I consent to behavioral health treatment with WMMHC for myself/minor child/designee.

I understand all clients of WMMHC are eligible to receive a range of services addressing substance use disorders, mental health disorders, and medical issues (as applicable) on a limited basis.

The type and extent of services I/my child receive(s) will be determined through a collaborative treatment team effort and through discussion with me/my child in the development of an individualized treatment plan.

I understand a range of behavioral health professionals, some of whom are in training, provide WMMHC services. Designated licensed staff provides oversight to all professionals in training.

I understand the various treatments offered provide significant benefits and may pose risks, which can be discussed with the treatment team. The process of behavioral health recovery may include relapse.

I understand some areas of WMMHC campuses are under camera surveillance to address safety and security concerns.

I understand the success of treatment is dependent, in part, upon motivation to change with the therapeutic support of WMMHC professional staff.

[Signature on Client Acknowledgement Form]

WESTERN MONTANA
MENTAL HEALTH CENTER

Client Rights

1. You have the right to be treated in a non-discriminatory manner with dignity and respect while receiving behavioral health services at any WMMHC facility.

2. You have the right to be treated without regard to physical or mental disability, unless such disability makes treatment afforded by the facility non-beneficial or hazardous. Treatment will reflect both your ability to benefit from services and others' treatment rights.

3. You have the right to practice your religion of choice, insofar as such practice does not infringe on the rights and treatment of others. You have the right to be excused from any religious practice.

4. You have the right to participate in the development of an individual treatment plan and any ongoing planning of your behavioral health services. You have the right to a reasonable explanation, in terms you can understand, of your general condition; treatment objectives; the nature and significant possible adverse effects of recommended treatment; reasons this treatment is considered appropriate; and what, if any, alternative treatment services and types of behavioral health providers are appropriate and available.

5. You have the right to be free from excessive or unnecessary medication. You have the right to give informed consent to take or not take antipsychotic or other medications if they are prescribed to you, unless the court has ordered differently or an emergency situation exists where your life or the lives of others are in danger.

6. You have the right to confidential records. Although you must give written approval to allow your records to be released in most cases, there are some exceptions to this rule under state and federal law.

7. You have the right to request access to your records and the right to request corrections or amendments to your records. These and other privacy rights are explained more fully in WMMHC's Notice of Privacy Practices.

8. You have the right to the maximum amount of privacy consistent with the effective delivery of services to you.

9. You have the right to appropriate treatment and related services under conditions that are supportive of your personal liberty.

10. You have the right to not be subjected to experimental research or other experimentation without your informed, voluntary, and written consent.

11. You have a right to be free from abuse and neglect, or threats of abuse and neglect, while receiving services at WMMHC.

12. You have the right to a humane psychological and physical environment while receiving services at WMMHC.

13. You have the right to receive information about WMMHC's client grievance procedure and how to file complaints. You must be allowed to exercise this right and other rights without reprisal, including reprisal in the form of denying you appropriate, available treatment. WMMHC recognizes that some clients may need assistance and/or support in filing their grievance. If clients request assistance in this respect, WMMHC will provide a referral to a local client support group, a family member's support group, or a state designated advocacy agency.

14. You have the right to communication with family in emergency situations.

15. You have the right to receive services which reflect the awareness of the special needs of gender.

16. You may have additional rights listed in Montana Statute, most of which apply to inpatient settings and jail diversion programs and rights during an involuntary commitment process. A member of your treatment team will explain these rights to you if you have concerns.

[Signature on Client Acknowledgement Form]

WESTERN MONTANA
MENTAL HEALTH CENTER

Client Responsibilities

As a partner in your healthcare, we will work with you to accomplish your treatment goals. On a separate document, we described your rights as our client. This document describes your responsibilities. Please do not hesitate to ask your clinician or provider if you have questions or concerns about these responsibilities.

Your responsibilities include:

- **Attend your scheduled appointments.** We will attempt to remind you of your appointment. Please make every effort to attend your appointment. If you won't be able to attend an appointment, please give as much advance notice as possible to the front desk. If we don't hear from you by the morning of your appointment, we may use your appointment for someone else.

- **Answer questions fully to the best of your ability**. Providing accurate and complete information to your care team will help them work with you to design your treatment plan and to make adjustments as needed.

- **Ask questions of your care team.** Since your treatment will be designed by you and your care team, making sure you understand what is being discussed is important.

- **Follow the Agreed-upon Treatment Plan.** You will make the final decision as to what your treatment plan will include. Make sure you understand and then follow this plan. If you wish to adjust your treatment plan, please let your care team know.

- **Update your care team.** If you are experiencing any changes in your health, your symptoms, or your living situation, please let your care team know so the changes can be incorporated into the ongoing treatment plan. Also, let your care team know if you have a living will, medical power of attorney, or advance directive.

- **Respect the Staff and other Clients.** Show respect for the rights and property of the staff and our other clients. Also, the staff may ask you to observe certain precautions which will be for the safety of all individuals. Please follow those instructions.

Thank you!

WESTERN MONTANA
MENTAL HEALTH CENTER

Grievance Procedure, Aggressive Behavior Policy, Smoking & Weapons

We will be working closely together so we want to be sure you are aware of how you can file a grievance and what behaviors you will need to avoid when working with us.

Grievance Procedure

We would like to resolve any concerns you have as soon as possible. Maybe times, a conversation to sort through miscommunications or misunderstandings will be enough to address the issue. If this does not resolve your concern, WMMHC has established a grievance procedure for clients who believe their rights have been violated by the Center. If you feel your rights have been violated, please ask for the Grievance form. The instructions to file the grievance are on the form.

Aggressive Behavior Policy

All WMMHC Programs are designed to provide a safe place for our clients and staff. Aggressive behavior does not fit into this philosophy and will not be tolerated at WMMHC facilities, against other clients or WMMHC staff. Aggressive behavior is defined as yelling, pushing, physical fighting, throwing objects, swearing, or acting in a manner perceived to be threatening. If aggressive behavior occurs, WWMHC will use the guidelines below to determine the appropriate course of action. The WMMHC staff member, possibly after consultation with a supervisor, may choose a different course of action or move through the steps more quickly, depending on the severity of the behavior.

STEP ONE: You/your child will be asked to leave the program/office for the day and you/your child will be referred to a member of your treatment team to address the aggressive behavior.

STEP TWO: You/your child will be asked to leave the program/office for one week. Prior to returning, you/your child will be required to meet with a member of your treatment team to develop a plan for adherence to the policy.

STEP THREE: You/your child will be asked to leave the program/office for 30 days. Prior to returning, you/your child will be required to attend a treatment team meeting to evaluate the appropriateness of continued participation in the program.

PLEASE NOTE: Due to the unique nature of 24-hour crisis programs, residential programs, and secure units as well as the CSCT programs, additional policies may apply in those programs.

Smoking & Weapons

WMMHC is invested in the health and well-being of clients and staff. All WMMHC facilities are non-smoking which includes all types of tobacco, vaping, and e-cigarettes. No firearms or weapons are allowed at any WMMHC facility.

WESTERN MONTANA
MENTAL HEALTH CENTER

PEOPLE WHO SUPPORT ME AUTHORIZATION*

Client Name: _____ Date of birth: _____

We, at Western Montana Mental Health Center, understand the important role families and friends play in our lives and in our healthcare. To support the role your family members and friends have in your care, we would like to understand who they are and how to reach them. We also wish to understand how much you would like us to share with them.

Name	Relationship	Contact Number	What to Share
			☐ updates (example: appointment dates, summary of progress) ☐ diagnosis ☐ everything ☐ involvement in treatment planning ☐ other: _____
			☐ updates (example: appointment dates, summary of progress) ☐ diagnosis ☐ everything ☐ involvement in treatment planning ☐ other: _____
			☐ updates (example: appointment dates, summary of progress) ☐ diagnosis ☐ everything ☐ involvement in treatment planning ☐ other: _____

By completing and signing this form, you are informing WMMHC of the individuals with whom **we may share information about you** as described above. You may revoke this authorization at any time. You may also decline to provide any names of individuals with whom we may communicate and still receive care.

Regardless of the above, this individual is my **emergency contact** should you need to reach me and cannot do so after reasonable attempts.

Name:	Relationship	Contact number

CLIENT SIGNATURE: _____ Date: _____

(*Instructions to staff on next page)

Revocation of Receiving information about me

I no longer wish to have _____ receive any information about me.

Signature:_____ Date:_____

***INSTRUCTIONS to STAFF PERSON RECEIVING THIS INFORMATION:**

1. Upload document to Client > Client Information > Personal Information > All Materials Collected > Add new event and select People Who Support Me; Description will be relationship from form above
2. Add emergency contact to Collateral area

WESTERN MONTANA
MENTAL HEALTH CENTER

Notice of Privacy Practices
Effective Date April 2017

Related to HIPAA – 45 CFR Parts 160 & 164 &
Substance Use Disorder – 42 CFR Part 2

THIS *NOTICE* DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. MEDICAL INFORMATION INCLUDES SUBSTANCE USE DISORDER INFORMATION.

OUR COMMITMENT AND LEGAL DUTY

Western Montana Mental Health Center recognizes the importance of maintaining the confidentiality and security of your protected health information or 'PHI' (individually identifiable information relating to your past, present or future health condition, provision of health care to you, or payment for that health care). As required by law, we maintain safeguards to protect your health information against unauthorized access, use, or disclosure. We are required to give you this notice to inform you of our legal duties and your rights concerning your protected health information, and how we may use or disclose that information. WMMHC is required by law to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make the revised Notice effective for health information we already have about you and any we receive in the future. A copy of the current notice will be posted in a common area of our facilities. You may also request a copy of this notice at any time or access it on our website (www.wmmhc.org).

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

As a health care provider, we use and sometimes disclose your PHI for the purposes of treatment (for example to coordinate your care with another provider), payment (verify eligibility and submit claims) and for health care operations (for example quality assurance and improvement activities). Except as outlined below, we will not use or disclose your protected health information for any other purpose or to any one else unless you have given us your authorization to do so. You may give us authorization to disclose your health information to anyone whom you designate. Your authorization must be in writing, using our Release of Information form designating what information may be released and to whom it may be released. You may revoke an authorization at any time but a revocation will not affect any use or disclosure permitted by the authorization while it was in effect.

Your PHI related to **substance use disorder treatment** is protected by additional Federal laws and regulations which provide a higher level of protection in some circumstances. For example, under these laws, WMMHC may not say to a person outside WMMHC that you attend the program, nor may WMMHC disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by federal law. Other exceptions to permitted uses and disclosures of information related to substance use are indicated in the following section in this notice.

Uses or Disclosure of Your Protected Health Information Permitted or Required **Without** Your Authorization

When required by law. For example, we may disclose PHI when a law requires us to report certain information, or in response to a court order provided that certain regulatory requirements are met. We may also disclose PHI as required or permitted by law to report suspected child abuse or neglect, and as required by authorities that monitor compliance with privacy laws.
In a medical emergency. We may disclose PHI to medical personnel in cases of medical emergency.
To avert threats to health or safety. In order to avoid a serious threat to health or safety, we may disclose PHI to law enforcement in certain situations such as when a threat is made to commit a crime on the program premises or against program personnel.
For research. We may disclose your information for scientific research if certain requirements are met.
Working with Business Associates. PHI may be disclosed to a qualified service organization or business associate who may perform various functions on our behalf or provide certain types of services such as WMMHC's legal counsel and our electronic health records system vendor. Agreements with such parties subject them to the same legal requirements regarding the protection of your PHI.
Relating to decedents. We may disclose certain information to coroners, medical examiners and/or funeral directors as consistent with the law.
Public Health / Health Oversight: We may disclose PHI as required to public health authorities and to a health oversight agency for activities authorized by law such as audits, investigations, inspections and licensure.
Treatment and Payment. We may use and disclose your PHI for treatment and payment purposes (described in the second paragraph of this notice). This does not apply to disclosures of Substance Use Disorder specific treatment information, which requires your authorization.
Military and Special Government Functions. If you are a member of the armed forces we may release information as required by military command authorities. We may also disclose information to Correctional Institutions or for national security purposes. This does not apply to disclosures of Substance Use Disorder specific treatment information, which requires your authorization.

Unless you object, we may also disclose your health information that is relevant to a family member, relative, close personal friend or any other person identified by you who is involved in your health care or payment related to your health care. This does not apply to disclosures of Substance Use Disorder specific treatment information, which requires your authorization.

Disclosures of Your Protected Health Information that **Require** Your Authorization
We will ask for your written authorization before we use or disclose your protected health information for any purpose other than those describe above. For example, we would require your authorization for the use or disclosure of psychotherapy notes in most cases (please note that progress notes are not considered psychotherapy notes). We would also require your authorization for uses or disclosures for certain types of marketing activities and any disclosure that constitutes a sale of health information.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information:

Right to Inspect and Copy. In most cases, you have the right to inspect and obtain a copy of your health information that we maintain in a designated record set. Usually, this includes health information that is used to make decisions about your care, as well as billing records, but does not include psychotherapy notes or information compiled for use in civil, criminal or administrative proceedings, or in other limited circumstances. You must submit your request in writing using our access request form, and we may charge a fee to cover the cost associated with providing you with a copy. In addition, we may deny your request to inspect and copy your information in certain limited circumstances. Depending on the circumstances of the denial, you may have the right to have this decision reviewed.

Right to Amend. If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend that information for as long as the information is kept by us. To request an amendment your request must be made in writing using our amendment request form. We may deny your request if, for example, we determine that your information is accurate and complete, or if the information was not created by us or is not part of the designated record set.

Right to Request Restrictions. You have the right to request a restriction or limitation on certain uses and disclosures of your health information. WMMHC is not required to agree to restrictions you request except under certain circumstances, but if it does agree, then it is bound by that agreement and may not use or disclose any information you have restricted, except as necessary in a medical emergency. Your request must be in writing and contain: the information you want to limit, whether you are requesting a limitation in the use or disclosure of your information, or both, and to whom you want the limitation applied.

Right to an Accounting of Disclosures. You have the right to request a list of disclosures of your health information made by WMMHC. We are not required to provide an accounting of disclosures made to you, disclosures made pursuant to your authorization or certain other disclosures otherwise permitted or required by law (for example, disclosures made for the purposes of treatment, payment or healthcare operations). Your request must be submitted in writing and must specify a time period which may not exceed six years. The first list you request within a 12-month time period will be free; we may charge a fee for additional lists requested within the same 12-month period.

Right to Choose How We Contact You. You have the right to request that we communicate with you in a certain way or at a certain location. For example, you may request that we contact you only by phone or mail or email and only at work or at home. These requests must be in writing to the address below. We will accommodate any reasonable requests.

Right to a Paper Copy of this Notice. You also have the right to receive a paper copy of this notice at any time.

Right to be Notified of a Breach. You have the right to be notified if a breach occurs that may have compromised the privacy or security of your information.

QUESTIONS AND COMPLAINTS

You may contact WMMHC if you have a question about this Notice. You may also file a complaint with WMMHC or with the Department of Health and Human Services, Office for Civil Rights if you believe your privacy rights have been violated. Violating these regulations is a crime; violations are reportable to the appropriate authorities. You will not be penalized for filing a complaint. To ask a question or file a complaint with WMMHC submit your question or complaint in writing to:

WMMHC Administration ATTN: Privacy Officer
1321 Wyoming Street
Missoula, MT 59801
406.532.8400

(client signature on Client Acknowledgement form)

WESTERN MONTANA
MENTAL HEALTH CENTER

Client Acknowledgment – Consent, Rights, and Behavior Expectations Mental Health

Please Initial Below to indicate you have received, read, and understand the following documents.

_____ Consent for Treatment

_____ Client Rights in the State of Montana

_____ Client Responsibilities

_____ Grievance Procedure, General Aggressive Behavior Policy, Smoking and Weapons

_____ Notice of Privacy Practices

_____ People Who Support Me form

Client Signature: _____

Printed Client Name: _____

Parent/Guardian Signature (if applicable): _____

Parent/Guardian Printed Name: _____

Date: _____

WESTERN MONTANA
MENTAL HEALTH CENTER

CONTRACT FOR PAYMENT OF SERVICES

Please read this fee agreement carefully and ask for any needed clarification. Please initial at the side of each statement and sign at the bottom.

By initialing each area, I attest that **I UNDERSTAND:**

_____ (initial)
1. I agree to pay <u>any and all costs not paid by a third party payer.</u> These costs may include: my deductible, co-insurance, and/or denial of coverage. If I do not wish to have my services billed to a third party or my insurance becomes inactive during treatment, I will be responsible for **payment in full.**

_____ (initial)
2. If I have Medicaid, I agree to pay <u>any co-pay established by Medicaid</u>. I understand that if my Medicaid becomes inactive during treatment or a service is not covered by Medicaid, I will be responsible for **payment in full.**

_____ (initial)
3. If I have Medicare, I understand that Medicare covers some but not all specific services offered by WMMHC. I agree to pay <u>any co-pay established by Medicare</u>. I understand that, if my Medicare becomes inactive during treatment or a service is not covered by Medicare, I will be responsible for **payment in full.**

_____ (initial)
4. I may qualify for public funding in order to offset a portion of my treatment costs. In order to qualify, I must provide proof of income. **<u>I understand if I do not provide the necessary documentation of eligibility, I will not qualify for public funding and will be responsible for payment in full.</u>**

_____ (initial)
5. In the event I do not qualify for public funding, I may be eligible for sliding scale fee services on the basis of my family income and number of dependents. In order to qualify, I must provide proof of income and complete an application. If I do not wish to provide the necessary documentation, I understand I will not qualify for sliding scale fee services and will be responsible for payment in full.

_____ (initial)
6. If my check is returned, I will be charged a returned check fee of $<u>25.00</u>.

_____ (initial)
7. If my income, situation, insurance coverage, address, or phone number changes, I will immediately notify WMMHC.

_____ (initial)
8. In the event I fail to pay fees as agreed upon, my account may be referred to a collection agency and/or law firm. If the event my account is sent to a collection agency and/or law firm, I will be liable for all costs associated with the collections process, including legal and demand costs.

_____ (initial)
9. I understand WMMHC cannot carry patient balances over 12 months from the last date of service. In signing this agreement, I agree to have the balance of my account paid in full within one year unless other arrangements have been made with the Accounts Receivable Department.

_____ (initial)
10. I understand this contract applies to any and all services rendered by WMMHC program and locations.

Client/Guardian Signature: _____ Date: _____

Client/Guardian Printed Name: _____

Staff Signature: _____ Date: _____

WESTERN MONTANA
MENTAL HEALTH CENTER

Authorization to Release Health Record Information

Name: _____ **Date of Birth:** _____

Address (mailing) _____ **Phone:** _____

_____

I authorize Western Montana Mental Health Center to:
____ receive from
____ release to
the following individual or agency information from my health record.

Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

_____

Dates of Treatment: _____ **to** _____

Information to be disclosed (please initial all that apply):

	Assessment		Medications List		Peer Support Notes
	Treatment Plan		Discharge summary		Nursing notes
	Progress Notes		Crisis evaluation		PACT or MACT notes
	Medical Notes		Group Home Notes		Crisis facility notes
	Consults		Day Treatment Notes		Safety plan
	Presence in treatment		Case Management Notes		Other

Purpose of Disclosure: _____

Please Read and Initial:

___ I understand this could include information related AIDS or HIV, psychiatric or mental healthcare, and/or substance use diagnoses and treatment.

___ I understand that, unless revoked, this authorization will expire one (1) year from the date of my signature or as follows, whichever occurs sooner. Specify date, event, or condition upon which this consent expires.
_____

___ I understand I may revoke this authorization at any time by notifying Administration at Western Montana Mental Health Center in writing at 1321 Wyoming Street, Missoula, MT 59801. This authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

___ I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations unless the recipient is subject to Federal or State laws prohibiting re-disclosure.

___ I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment from Western Montana Mental Health Center except where disclosure of the information is necessary for treatment.

___ I understand I may request and receive a copy of this form after I sign it.

___ I have received a copy of Western Montana Mental Health Center's Notice of Privacy Practices.

By signing below, I acknowledge I have read and understand this Authorization.

Client or Guardian Signature: _____ **Date:** _____

Guardian Printed Name, if applicable: _____

Relationship to Client: _____

Informed Consent for Email, Voicemail, Text Message, Photo Transmission of Communication

Client Name: _____ Date of birth: _____

You may give permission to WMMHC employees to communicate with you by email, voicemail, and text message (also known as SMS). Text messages may also include photos of client information or likeness. This form provides information about the **risks of these forms of communication**, includes **guidelines** for email, phone, and text communication, and describes **how we will use email, voicemail, and text communication**. This form will also be used to document **your consent** for communication with you by email, phone, and text.

RISKS of USING EMAIL and TEXTING Include:

- Emails, voicemail, and text can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients
- Email and text senders can easily misaddress an email or text and send the information to the wrong person
- Back up copies of emails and texts may exist even after the sender and the recipient has deleted their copy
- Employers and online services have a right to inspect emails sent through their company systems
- Emails, voicemail, and texts can be intercepted, altered, forwarded, or used without permission or even the intended person knowing
- Emails, voicemails, and texts can be used as evidence in court
- Emails, voicemails, and texts may not be secure and therefore it is possible the communications may be intercepted by a third person

CONDITIONS FOR THE USE OF EMAIL and TEXT:

We will make reasonable efforts to maintain the security and confidentiality of email, voicemail, and text information we receive and send. We cannot, however, guarantee these messages will remain secure and confidential. We cannot be responsible for improper disclosure of information if it is not caused by our intentional misconduct.

ACKNOWLEDGEMENT and CONSENT:

- WMMHC cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time. We will respond to text, voicemails, and emails within our normal business hours.
- Email, voicemail, and texting is not appropriate for urgent or emergent situations. Please call 911 or go to your nearest emergency department.
- Emails and texts should be concise and short. To discuss complex and/or sensitive situations, please call to schedule an appointment.
- Emails and texts may be filed in your medical record.
- Emails and texts should not be used for the communication of sensitive information.
- WMMHC is not liable for breaches of confidentiality caused by the client or any third party.
- It is your responsibility to follow up or schedule an appointment if needed.
- Services provided by WMMHC to you via telephone may be billed to your insurance.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge I have read and fully understand this consent form. I understand the risks associated with communication of email, voicemail, and texts between WMMHC employees and me and I consent to the conditions and instructions outlined above, as well as any other instructions WMMHC may provide in order to communicate with me by email, voicemail, and text. By signing this form, I authorize WMMHC to send text messages to my cell phone regarding scheduling and treatment. I understand that standard text messaging rates will apply to any messages I receive. I also understand that I or WMMHC may revoke this consent in writing at any time. I will notify WMMHC in the event my cell phone number or email address changes.

Signature: _____ Date: _____
Client/Parent/Legal Guardian

Printed Name: _____ Date of Birth: _____