LIFEQUEST
BEHAVIORAL HEALTH CARE

Minor Consent Packet and Information

Client Information: ***Must be filled out**

*Minors First Name:_____ *Minors Last Name:_____

*Date of Birth: ____/____/_____ *Pronouns:_____

*Primary Address: _____ 2nd Address:_____

*City:_____ *State:_____ *Zip Code:_____

*Administrative Sex: Male or Female (circle one)

Primary Parent/Guardian: (this parent/guardian is the first # we call regarding minor)

*First Name:_____ *Last Name:_____

*Date of Birth: ____/____/_____ *Pronouns:_____

*Primary Phone #:_____Relation to Minor:_____

*Email Address:_____

*Address: _____ 2nd Address:_____

*City:_____ *State:_____ *Zip Code:_____

Other Parent/Guardian:: (must be a legal guardian)

*First Name:_____ *Last Name:_____

*Date of Birth: ____/____/_____ *Pronouns:_____

*Primary Phone #:_____Relation to Minor:_____

*Email Address:_____

*Address: _____ 2nd Address:_____

*City:_____ *State:_____ *Zip Code:_____

Client Portal:***Must be filled out**

***Please initial that you have read over the above information:_____**

LifeQuest uses an online system where clients can have reminders sent to them via text, email or both. The client portal allows access to update your personal information, payment cards, insurance and sign paperwork for your clinicians at any time.
***Please mark and provide where you would like the reminders and notifications sent.**
(Email is the only way to receive document notification updates).

- Email & Text Reminders/Document notifications(circle one):
  use info of primary parent/guardian, other parent/guardian or other number/email provided below:

  _____
- Text Reminders Only(circle one):
  use info of primary parent/guardian, other parent/guardian or other number provided below:

  _____
- Email Reminders Only(circle one):
  use info of primary parent/guardian, other parent/guardian or other email provided below:

  _____

Insurance Coverage Information: ***Must be filled out**

***Please initial that you have read over the above information:_____**

*Insurance Name:_____

*Member ID/Reference#:_____

*Subscribers Name:_____

*Relation to Subscriber (circle one): Self/Spouse/Child

*Subscribers Birth date:____/____/_____

*Subscribers Administrative Sex (circle one): Male or Female

Secondary Insurance:

(please disregard if you only have one insurance)

*Insurance Name:_____

*Member ID/Reference#:_____

*Subscribers Name:_____

*Subscribers Birth date:____/____/_____

*Relation to Subscriber (circle one): Self/Spouse/Child

*Subscribers Administrative Sex(circle one): Male or Female

Party Responsible for Payment for Minor: ***Must be filled out**

*First Name:_____ *Last Name:_____

*Date of Birth: ____/____/_____

*Primary Phone #:_____Secondary Phone #:_____

*Email Address:_____

*Address: _____

Financial Responsibility & Assignment of Benefits: ***Must be filled out**

(please disregard if you have medicaid has primary or secondary insurance)

The client (or client's guardian, if a minor) is ultimately responsible for the payment for

***Please initial that you have read over the above information:_____**

treatment and care. LifeQuest will bill your insurance for you if you are within their provider network. **However, the client is required to provide the most correct and updated information regarding insurance.** If we are not within your insurance provider network, we can provide a Superbill which you can submit directly to your insurance for a refund. Clients are responsible for payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by your insurance plan. Copays are due at the time of service unless other arrangements have been made. Clients may be required to, and are responsible for payments of additional charges if applicable. These charges may include:

***Please Initial below that you have read the following:**

_____ Late cancellations(less than 24hr notice)/No Show Fee- **$125**
_____ **Any cost** associated with with the collection of a client's balance
_____ Returned checks fee- **$25**

By my signature below, I hereby authorize assignment of financial benefits directly to LifeQuest Behavioral Health Care and any associated healthcare entities for service rendered as allowable under standard third-party contacts. I understand that I am financially responsible for charges not covered by this assignment. I have read, understand, and agree to the provisions of this Financial Responsibility and Assignment of Benefits section.

Cancellation Policy:

To make the most of your therapy, it is to your benefit for you to commit to attending all scheduled sessions. We understand that occasional emergencies arise beyond your control, at which time it is important for you to contact LifeQuest to

reschedule or cancel your appointment. We require a minimum of 24-hour notice but prefer as much notice as possible. **Clients will be charged a $125 fee for a less than 24 hour notice or for not showing up to your appointment.** Please note that Medicaid and other Insurance companies only pay for sessions that are attended by the client and clinician.

Thus, it is LifeQuest's policy that **after 2 missed appointments without 24-hour notice,** the clinician may remove you from their regular schedule and place you on a waiting list for the next available on-call appointment. Our goal is to contact clients on the waiting list as soon as possible to allow enough time to accommodate their schedule, but there is no guarantee of time or frequency of these appointments.

Client's Rights:

All persons receiving services shall retain all rights, benefits, and privileges guaranteed by the laws and constitution of the state of Nevada and the United States of America, except that specifically lost through due process of law.

LifeQuest rules shall not be more restrictive than these rights.

***Please initial that you have read over the above information:_____**

- You are entitled to be treated in a professional, courteous, and caring manner that respects and appreciates differences related to race, ethnicity, national origin, gender, sexual orientation, religion, personal values, age, disability, and economic or veteran status.
- You are entitled to request the mental health provider(s) of your choice or to change your provider, as well as to request a second opinion.
- You are entitled to have LifeQuest representatives and your provider conduct themselves in an ethical manner in accordance with our "code of ethical conduct" and to have such services provided with no mental, physical, or financial abuse.
- You are entitled to receive services in a way that respects your dignity and privacy and that promotes your autonomy.
- You are entitled to have your records kept confidential in accordance with the law.
- You are entitled to your mental health provider's independent professional judgment and undivided loyalty uncompromised by conflicts of interest.
- You are entitled to have your questions and concerns addressed in a prompt manner and to be allowed to participate meaningfully in the development of your treatment program.
- You are entitled to have the expense of services provided explained to you at the onset of services.
- You have a right to file a grievance and to have that policy and procedures presented to you in writing.

Limits of Confidentiality:

Confidentiality is the promise to keep your personal and private information from being shared or given to another person, agency, or authority without your written permission. All staff, administration, supervisors, clinicians, clinician interns, and clinicians-in-training are required to keep your information private and confidential.

Under the Federal Law, Nevada Revised Statutes (Law), and the professional codes and standards of clinicians require clinicians to report and tell certain information to responsible persons at state agencies. It is the professional and legal

duty of clinicians to give information about you to others with or without your written "Okay" for the following reasons:

- To stop a serious threat to yourself or another person's health and safety.
- To report child abuse or neglect or elder abuse or neglect.
- In response to written Order of the Court or where otherwise required by law.
- To the extent necessary for emergency medical care to be rendered

When we do give information, we give only the key and necessary information to meet our duty. If possible, we try to let you know ahead of time. By initializing this form, you are saying you understand the limits of your confidentiality or the limits to the protection of your private and personal information.

HIPAA Information:

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. HIPAA provides 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 protection to you as the client. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services (www.hhs.gov).

Our Policies:

***Please initial that you have read over the above information:_____**

- Client 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 includes the sharing of information with other health care providers, health insurance payers, as is necessary and appropriate for your care. Client records may be stored in files. The normal course of providing care means that such records may be left, at least temporarily in administrative area such as the front office. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized with the office for the handling of charts, patient records, PHI, and other documents of information.
- It is the policy of this office to remind clients of their appointments. We may do this by telephone, e-mail, U.S. mail or by any means convenient by the practice or requested by you.
- You understand and agree to a review of documents, which may include PHI, by insurance payers in the normal performance of their duties.
- You agree to bring any concerns or complaints regarding privacy to the attention of LifeQuest management.
- Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
- We agree to provide clients with access to their records in accordance with state and federal laws.
- We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the client.
- You have the right to request restrictions in the uses of your protected health information and to request a change in certain policies used within the office concerning your PHI. However, we are not obligated to conform to your request.

Informed Consent:

LifeQuest is dedicated to providing culturally sensitive, accessible, and effective mental health/behavioral health services for minors, adults and families. With an emphasis on quality over quantity, LifeQuest's commitment is to support and assist those we serve in advancing toward a more productive, healthy, and happy life. Our vision includes a positive impact for minors, adults and families affected by disability, trauma, violence, abuse, and neglect and more.

The following describes information for clients who request individual, couple, family, or group services from any provider of LifeQuest. Please review the following information carefully and voice any questions or concerns you have. By initialing each

part below and signing at the end you understand and agree that you are giving your informed consent for services provided by LifeQuest.

- I give consent for information exchange between my insurance and their authorized representative and the Rehabilitation service provider(s) as necessary for treatment and payment operations for so long as I am receiving therapeutic and rehabilitation services from LifeQuest Behavioral Health Care.
- Counseling services at LifeQuest are provided by Nevada licensed clinicians, Nevada licensed clinicians interns, and clinicians-in-training practicum students under the supervision and direction of a Nevada licensed clinicians. I understand that any meeting I have with my clinician may be discussed with the clinician's supervisor, other clinic clinicians or professional consultants. I understand that, by signing below, I am a client of LifeQuest. Therefore, my case file may be reviewed by appropriate LifeQuest staff for program and insurance compliance.
- I understand that LifeQuest's therapeutic program is designed to enhance the emotional development of myself and to encourage prosocial and responsible behavior. The therapeutic process may result in a person or persons modifying feelings, conditions, attitudes, and behaviors that are emotionally, intellectually, or socially ineffective or maladjusted.
- I understand that throughout the counseling process issues might become more difficult before they improve as uncomfortable feelings and reactions, such as sadness, anxiety, anger, and so on, may come up. However, therapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But there are no guarantees about what will happen. Therapy requires a very active effort on my part. In order to be most successful, I will have to work on things we discuss outside of sessions.
- I also understand that the program uses a "hands off" approach to managing clients and does not practice physical restraint; therefore, I recognize that my participation in the program is contingent upon my ability to maintain safety for myself and others.
- Except as stated above in the Limits of Confidentiality and in the Informed Consent, my personal and private information is not shared or given to another person, agency, or authority without my written permission.
- In the event that either my clinician or I deem therapeutic services to be unhelpful or not beneficial, therapeutic alternatives can be discussed which can include

changes to my treatment plan, the termination of our therapeutic relationship, or a referral to another helping professional. LifeQuest will provide me with the names and contact information of other programs or services if I ask, if LifeQuest cannot meet my needs, or if LifeQuest is unable to provide me services at the time when I need them.

- If I am seeing another professional outside of LifeQuest, such as a doctor, psychiatrist, or another clinician, I will inform my clinician. If appropriate and necessary, I will provide written permission for my clinician and that professional to work together in providing services.
- The laws and standards of my clinician's profession require that they keep treatment records. Although therapy often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here, what was done in session, progress, diagnosis, and a general mention of the topics discussed.
- As your clinician, I agree to enter into a professional relationship with you and to maintain your privacy which extends to the community and online/social media forums. In an effort to uphold confidentiality, I will take cues from you during and if we have a public encounter. While I intend to be courteous and professional should you greet me, do not feel obligated to do so. Please note that I will not be referencing our therapeutic work together in the event that you do approach me. Should you have any concerns or questions following such an encounter, feel free to voice them during our next session together.
- Appointments will ordinarily be 55 minutes in duration, once per week at a time that is agreed on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. You are responsible for coming to your session on time. If you are late, your clinician could choose to see you but your appointment will still need to end on time. If you are too late the clinician will ask you to reschedule your appointment.
- In an emergency, please call 911, 988 or go to your local emergency room for safety purposes. Note you may attempt to call your clinician if a crisis or emergency occurs at the LifeQuest office (775)622-8890 Sparks / Reno. Your clinician will get back to you at their earliest convenience.

Therapy With Minors:

As clinicians working with minors it is our goal to create a safe place for things to be discussed with their clinician. As such, conversations between the minor and clinician remain privileged, with exceptions to confidentiality noted below. It is LifeQuest's policy to provide the legal guardians with updates regarding treatment status and

progress/regress toward treatment plan goals and objectives. If records are requested, clinicians reserve the right to use discretion or prohibit parent/guardian access if it is not in your child's best interest. If the clinician ever believes your child is at risk of serious harm to themselves or someone else or there is suspicion of abuse or neglect by an adult or the minor is under age 16 and has been involved in sexual activity with a person aged 18 or older, the clinician will inform the legal guardians and/or the appropriate authority. In such situations, every effort will be made to notify the child of the clinician's intention to disclose and provide an opportunity to support the minor and address their concerns.

As the minor is the client of LifeQuest Behavioral Health Care, the clinician's priority is the minor. From time to time legal guardians and other trusted parties might be asked to step into sessions or actively participate in ongoing family therapy. These sessions are meant to enhance the parent/child relationship and overall quality of care of the client. Although family therapy benefits all parties, the minor remains the client of record. LifeQuest clinicians will not testify in court, whether in person, or by affidavit. In addition, the parents and guardians of the minor agree they will instruct their attorneys not to subpoena LifeQuest clinicians to testify. LifeQuest clinicians are not custody evaluators and are therefore not qualified to provide an opinion on custody arrangements. If the clinician is required to testify, they are ethically bound not to give their opinion about either custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, the clinician will provide information as needed, but the clinician will not make any recommendation about the final decision.

Custodial Rights: ***Must be filled out**

As legal guardian please fill in the information below:

Do you have full legal custody of the minor?

- Yes, legally married to other guardian
- Yes, will provide legal documentation (court docs, divorce docs, guardian paperwork, etc..)

- No, will provide other guardians information.
- No, other guardian is unreachable.

If answered above: Yes, will provide legal documentation. Please add which type of documentation that will be provided

_____

If answered above: No, will provide other guardians information. Please add the information below

_____

Communication with Clinicians:

Communication between client and clinicians is limited to scheduling of appointments and will be answered at the clinician's earliest convenience. Due to delay in response time, clinicians cannot respond to emergency or crisis texts or phone calls.
In the event of an emergency, please call 911, 988 or local crisis hotline: 1(800)273-8255.

I certify that I have received the intake packet with consents. I understand I have a right to receive any copies of this document or documents that I sign. The intake packet with consents has been fully explained to me and I have read through it. I certify that I understand the packet and consents. If I have any questions or concerns, I may contact the clinician or the administrative staff at (775) 636-7767 Reno **My signature below certifies that I have agreed to all parts that I have initiated and signed above.**

***Signature:**_____

*__Print Name__:_____

***Date**____/____/____ ***SS Representative signature:**_____

***Please initial that you have read over the above information:**_____

Emergency & Other Contact Form:

First Name:_____ Last Name:_____

Date of Birth: ____/____/_____ Pronouns:_____

Primary Phone #:_____Secondary Phone #:_____

Email Address:_____

Address: _____ 2nd Address:_____

City:_____ State:_____ Zip Code:_____

Relation:_____

- Emergency Contact
- Guardian
- Primary Care Physician

First Name:_____ Last Name:_____

Date of Birth: ____/____/_____ Pronouns:_____

Primary Phone #:_____Secondary Phone #:_____

Email Address:_____

***Please initial that you have read over the above information:_____**

Address: _____ 2nd Address:_____

City:_____ State:_____ Zip Code:_____

Relation:_____

- Emergency Contact
- Guardian
- Primary Care Physician

LifeQuest Behavioral Health Care Telehealth Informed Consent

Minimize disruptions to care, telehealth psychological services are available and will be utilized via a HIPAA-compliant communication platform.

I (print your name)
_____have

read the above statement and consent to receiving psychological services via Telehealth *(check all that apply)*:

- A HIPAA-compliant video conferencing via TherapyNotes or other HIPAA-compliant communication. use info above or other email provided below (circle one):
  _____

- Telephone:use info above or other number/email provided below (circle one):
  _____

If signed by other than client, specify relationship to client:
_____(must be a legal guardian)

***Please initial that you have read over the above information:_____**

Client/Representative Signature: _____

Date: ____/____/____