VALLEY | CITIES
Behavioral Health Care

School Based Consents for Treatment

I _____ hereby voluntarily consent to receive mental health counseling as part of the School Based Counseling Program at Valley Cities Behavioral Health. I request and authorize the staff at Valley Cities Counseling & Consultation to evaluate, treat or provide consultation to myself or to the individual of whom I am the parent or legally constituted guardian. All clients age 13 years and older must sign that they are voluntarily consenting to treatment as above.

I give my permission to contact my Emergency Contact in the event of an emergency.

Confidentiality

Generally, the information you pass on to a clinician is not discussed outside of your treatment team. Valley Cities will not disclose information that you have given unless:

- You sign a release of information authorizing us to disclose this information (parents of children twelve (12) and under are responsible for providing this permission).
- Your clinician thinks you are in danger of harming yourself or someone else.
- Your clinician has any reason to suspect a child, a developmentally disabled person, or an elderly person is being abused or neglected.
- The release of information is court ordered or otherwise legally required.
- Other reasons for release as allowed or required by law, specified in the Notice of Privacy Practices and the Washington Department of Health booklet Consumer and Counselor Responsibilities and Rights.
- In a school setting the school is responsible for all students in their care. If a student discloses that they have illegal substances for the purpose of selling/distributing or any weapons on school property Valley Cities staff will advise school staff so they can follow their procedures.

School Based services occur in a small community and your clinician may provide services to other students you know. Your clinician will protect your confidentiality by:

- Not acknowledging you in a public setting unless you acknowledge your clinician first.
- Never sharing your information with another student, including engagement in services.

Family members or friends cannot see or receive information about your records without a signed release. Your clinician cannot tell them anything without your written permission, but they can listen to information they share or give them general information about mental illness and services that are available.

Telehealth Consent

1. I may refuse consent for telehealth services at any time without it affecting my right to continue services with Valley Cities. Valley Cities may discontinue telehealth services if those services do not appear to be a benefit to me therapeutically.
2. I will not share my telehealth appointment link or information with anyone who is not approved to attend the session. I understand that I am responsible to ensure privacy at my location and that Valley Cities will ensure privacy at their location. I am aware that confidential information may be discussed during a telehealth session.
3. I understand there are potential risks to using telehealth, including but not limited to interruptions, unauthorized access to the session, and technical difficulties. Valley Cities is not responsible for technical difficulties over which they have no control.
4. I will not record audio or video of any telehealth session. Valley Cities will not record a telehealth session unless I am informed and provide written consent.
5. If I have questions about telehealth, I may discuss these with Valley Cities at any time.

☐ I Consent to Telehealth ☐ I DO NOT Consent to Telehealth

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Electronic Communication

- Email and text messaging allows Valley Cities providers to exchange information efficiently for the benefit of our clients. 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.
- When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet.
- In addition, once the email is received by you, someone may be able to access your email account and read it.
- 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.
- If you would like us to send you email and/or text messages that contains your health information, including scheduling reminders or communication, please complete and sign this consent.
- I understand that this form of communication is NOT to be used for urgent or emergent situations. Anything that requires an immediate response from Valley Cities must be communicated by phone or in person.

I consent to the following form(s) of electronic communication:

☐ Text messages to myself (must be age 13+)

☐ Email communication to myself (must be age 13+)

☐ Text messages to my legal guardian or representative (specify name below)

☐ Email communication to my legal guardian or representative (specify name below)

☐ I DO NOT consent to any form of electronic communication (email or texts).

☐Received Consents for Clients with *Medicaid only* • Valley Cities Consumer Handbook • King County Notice of Privacy Practices • Washington State Publication What to Expect from your Licensed Counselor. • Washington State Publication Mental Health Advance Directives, Information for Consumers (for clients 18+ and emancipated minors)

☐Family Initiated Treatment for youth 13-18 declining to consent. Treatment for 12 sessions or 3 months.
Date Initiated (date of intake) _____
*Only select if you are a parent of 13+ and child is not consenting to treatment and as the parent you are initiating treatment. Note: treatment eligibility is determined on assessment

By signing below, I also acknowledge that I have read and understand my client rights and consent to each section above and that I have received the following forms and documents:
Valley Cities Notice of Privacy Practices & SBC Feedback and Client Complaint Procedure

Client Name: _____ Client Signature _____ Date_____

Caregiver Name: _____ Caregiver Signature: _____ Date_____