**PERSONAL INFORMATION AND CONSENT TO SERVICES**

**Legal Name: Legal Guardian:**

**Preferred Phone: Message Phone:**

**Tribe: Enrollment #: IHS Chart #:**

**Client Related Family Information: (Parents, Sisters, Brothers, Others living in household)**

**Names/Ages:**

|  |  |
| --- | --- |
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**Are you taking any medications? YES❑ NO❑ *If YES*, *please bring all of your medications and supplements to your next appointment for charting.***

|  |  |
| --- | --- |
| **Physician’s Name:** | **Prescriber’s Name:** |

**FINANCIAL INFORMATION:**

**Medical Coupons ❑ No Fee ❑ Insurance ❑**

**Insurance Name: Name of Insured:**

**Group Number: ID Number:**

**Co-Pay:**

**Please read the following statements carefully. We will discuss any questions you have concerning this information.**

Conversations between you and your Provider are confidential.

YNBHS is a covered entity that may disclose confidential information in certain cases. Please refer to the Washington Notice Form that you have received for extended explanation of disclosure of your PHI (Protected Health Information). We may use or disclose PHI without your consent or authorization in the following circumstances:

* Child and Elder Abuse
* Abuse of Mentally Ill or Developmentally Disabled Adults
* Serious Threat to Health or Safety
* Worker’s Compensation
* Judicial or Administrative Proceedings
* Health Oversight

There are many programs available at YNBHS which may be part of your care plan. To best serve you and your care needs, we may share administrative information about your care within these programs. Administrative information includes: changes to your contact information, program enrollment, attendance status, referral status, or emergency services. Administrative information does not include: personal information discussed during your appointment, interventions, or treatment plans.

This consent to treatment is good until you withdraw it in writing or until the end of treatment.

There is NO cost to you for these services. YNBHS is taking part in suicide prevention efforts, information on suicide risk, treatment & referrals made will be used for this purpose. No personal identifiers will be linked to these reports.

**CLIENT STATEMENT: I Authorize Yakama Nation Behavioral Health Services to bill my insurance company for services and to release information concerning my mental health as requested for Treatment, Payment, and Health Care Operations as defined in the Washington Notice Form. I have been offered the Washington Notice form and the Provider-Client Services Agreement and / or a Program Specific Service Agreement. I understand the above statements and consent to services.**

Please circle and sign: I ACCEPT I DECLINE to take the Yakama Nation Behavioral Health Services Policies and Practices to Protect the Privacy of Your Health Information and Provider-Client Services Agreement and / or Program Specific Service Agreement.

Client Signature: Date:

**If client is UNDER 13 years old:**

Name of parent / legal guardian: Date:

Signature of parent / legal guardian: