YAKAMA NATION BEHAVIORAL HEALTH PROGRAM

PERSONAL INFORMATION AND CONSENT TO TREATMENT

DATE:_____

Legal Name:_____ **Legal Guardian:**_____

Preferred Phone:_____ **Message Phone:**_____

Mailing Address:_____

Physical Address:_____

Gender: **Male❑ Female❑** **Date of Birth:**_____ **Age:**_____

SS#:_____ **Ethnicity:**_____ **Marital Status:**_____

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

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

Names/Ages:

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

Physicians Name:	**Prescriber's Name:**

FINANCIAL INFORMATION:

Medical Coupons ❑ No Fee ❑ Insurance ❑

Insurance Name:_____ **Name of Insured:**_____

Group Number:_____ **ID Number:**_____

Co-Pay:_____

YAKAMA NATION BEHAVIORAL HEALTH PROGRAM

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

Conversations between you and your Therapist 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). I 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**

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. The YNBH 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.

I Authorize Yakama Nation Behavioral Health 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 (Yellow). I have been offered the Washington Notice form and the Psychotherapist-Patient Services Agreement (Blue) and understand the above statements and consent to treatment.

Please circle and sign: I Accept I Declined to take the Yellow and Blue Forms

Signature:_____

Signature of Guardian (if Under 13 years of age)_____