Behavioral Health and Education Specialists

Consent For Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information (PHI) by Behavioral Health and Education Specialists, Inc. (BHES) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills and/or to conduct healthcare operations of BHES.

I understand that my diagnosis or treatment by a BHES provider may rely upon my consent as shown by my signature on this form. For individuals between 12 and 17 years old, parental consent is required following the fifth appointment.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations of BHES. BHES is not required to agree to the requested restrictions; however, if BHES agrees to the restriction, the restriction is binding on BHES and the treating provider.

I have the right to revoke this consent, in writing, at any time, except to the extent that my treating provider at BHES has taken action and reliance on this consent, by filling out the Consent for Purpose of Treatment, Payment and Health Care Operations Revocation form.

My "PHI" means health information, collected from me and created or received by my treating provider, including my demographic information, health insurance plan, employer(s) or a health care clearinghouse. My PHI relates to my past, present or future physical and/or mental health condition which identifies me or to which there is a reasonable basis to believe the information identifies me.

The Notice of Privacy Practices (Notice) describes the types of uses and disclosures of my PHI that will occur in my treatment, payment or health care operations of BHES. This Notice also describes my rights and the duties of BHES with respect to my PHI.

BHES reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised Notice by requesting a copy be sent in the mail or asking for one at the time of my next appointment.

I understand my right to review the Notice prior to signing this document.

_____ _____

Patient/Parent/Guardian (if patient is under 12 y.o.) Signature Date

_____

Patient/Parent/Guardian (if patient is under 12 y.o.) Printed Name

(If Patient is between 12 and 17 years old) By signing below, I am consenting to the treatment of my child following the fifth appointment at BHES.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name