Statement of Understanding

Participant Information	
Name (First and Last Name Printed)	Today's Date

Statement of Understanding

This program is provided to help you with issues that affect the quality of your life. The decision to receive services is strictly voluntary. We provide assessment, problem resolution, and referral services for a wide range of personal and/or professional problems.

The program and/or your provider is PROHIBITED to complete any type of paperwork/documentation for you. Your provider will communicate verbally and in writing with your BHS team to discuss your assessment, progress and referral options. If you need to cancel an appointment, please do so within 24 hours of the appointment. Late cancellations and no shows will take away from the number of sessions you are allotted. Services are free; however, if your problem is assessed as requiring specialized or extended services beyond those provided by BHS, a referral will be made to other resources for which you will be financially responsible. In many cases, some or all of the cost for additional sessions or services will be covered by your health insurance. BHS, its providers and/or contractors, and your sponsoring organization are not responsible for any costs and/or services for which you may be referred to beyond BHS.

Your use of the services and the information you share is protected against disclosure by Federal Confidentiality Laws, except if your BHS team: 1) becomes aware of threats of suicide or homicide 2) suspects a child or vulnerable person has been abused or neglected 3) becomes aware of an active worker's compensation claim 4) receives a court order to release your records 5) becomes aware of state, federal or public property being at risk of harm, or of public safety being at risk of harm 6) knows that you are under the age of 18 and your parent/guardian requests access to your records. Depending on the privacy policy of your sponsoring organization, there may be a privacy official who can access information in connection with obligations in the Privacy Rule under HIPAA (the Health Insurance Portability and Accountability Act). You may choose to sign a release of information to involve third parties, who may be able to assist in achieving your goals through BHS. If you are employed in a safety sensitive position that may have regulatory ties, you are encouraged to contact your union representative regarding BHS participation and confidentiality. If your sponsoring organization has an internal team of mental health professionals and has contracted with BHS for supplemental support, information you share with BHS may be shared with a member of that internal team.

Upon intake, BHS offers to send you a copy of our "Notice of Privacy Practices" form which describes how your protected health information may be used and disclosed and how you can get access to this information. You may obtain additional copies by contacting BHS by phone or by downloading it from our web site at www.bhsonline.com.

Video and/or telephonic sessions may be available and offered to those whose needs are assessed as being appropriate for this mode of service. You must be physically in the state the provider is licensed in during all sessions. These alternative modes of assistance have certain limitations, including disruptions in the service and quality of the technology used. It is recommended you always have your phone (or a land line for telephonic sessions) available and you and your provider know each other's phone numbers. If you get disconnected from a video session, restart the session. If you are unable to reconnect within 5 minutes, call your provider. You are responsible for initiating the connection with the provider at the time of your session. So that we are able to get you help in the case of an emergency, you must inform your provider of the location in which you will be during each session.

I have read and understand this statement, and consent to all modes of services offered. I have had the opportunity to receive/review a copy of BHS' Notice of Privacy Practices. Any areas of concern have been discussed with my provider.

Participant's Signature:_____ Date: _____

Provider's Signature:_____ Date: _____