CROSSWINDS COUNSELING & WELLNESS

CONSENT TO TREATMENT AND FOR USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I consent to treatment and services delivered by the clinical staff of CrossWinds Counseling & Wellness. CrossWinds is a teaching facility and I understand that interns may be a part of my treatment as an observer or co-therapist. I also understand that mental health treatment and services may involve risks and there is no guarantee that the outcome of my treatment will meet my expectations.

CrossWinds uses the technology of tele video services. Tele-behavioral Health involves the use of electronic communications to enable staff to provide services to individuals who would otherwise not have adequate access to care. I understand, I may be set up with this service and understand there are potential risks of technology, including interruptions, unauthorized access, and technical difficulties.

CrossWinds service providers may utilize a virtual note-taking system known as ELEOS Health Software to aid in documentation. This secure and HIPAA-compliant technology captures session dialogue in real time and generates a summary in the form of a progress note, operating discreetly during your session. Importantly, ELEOS does not record the session or access any personal information. After a progress note is created, your CrossWinds' provider may review it with you to ensure it accurately represents the session. The information is protected through end-to-end encryption and stored securely in a cloud-based, password-protected environment. You acknowledge that your decision to consent or refuse is entirely voluntary and will not impact the services you receive. By signing below, you agree to the use of ELEOS Audio for documenting your sessions.

I understand that as a part of my health care, CrossWinds receives, originates, maintains, discloses, and uses individually identifiable health information. This includes, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, billing, and health insurance information. I understand that CrossWinds staff may use this information to perform the following tasks:

- Diagnose my medical/psychiatric/psychological condition
- Plan my care and treatment
- Communicate with other health professionals in the Center concerning my care
- Disclose Protected Health Information (PHI) to insurance companies and other party payer's or agents, to the extent necessary to collect payment for treatment and services rendered by CrossWinds
- Conduct routine health care operations, such as quality assurance, utilization review (the process of monitoring the effectiveness of health care personnel).
- Collect and share information through assessments, for the purpose of improving quality measures.

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that CrossWinds has already taken action to my earlier effective consent. I have been informed if I have concerns about the protection of my rights, including my privacy rights; I may contact the CrossWinds Executive Director, CrossWinds Compliance/Risk Manager at 620 343-2211 or the Secretary of Health and Human Services at 1-877-696-6775 (toll free).

I have been offered a copy of CrossWinds Consumer Handbook, which includes the Client's/Consumer's Rights and Notice of Information Practices. CrossWinds has given me a verbal explanation and afforded me sufficient time to review this Notice, prior to signing, and has answered any questions to my satisfaction. I also understand that CrossWinds cannot use or disclose my individually identifiable health information other than as specified on the Notice. I also understand, however, that they reserve the right to change its notice and the practices detailed therein prospectively.

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment, and health care operations, but that if I do not consent, CrossWinds may refuse to provide me health care services unless applicable state or federal law requires them to provide such services.

I understand that I have the right to request restrictions/objections on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that CrossWinds is not required to agree to the requested restriction but that, if they do agree, they must honor the restriction unless I request, they stop doing so or CrossWinds notifies me that they will no longer honor the request.

I am aware that CrossWinds' staff may need to communicate with me through written correspondence, telephone, email and/or texting. CrossWinds is not responsible for change of phone numbers or email address. If these numbers change it is my responsibility to inform them of these changes. I will be liable for any charges not covered by my data plan.

If Legal Authorized Representative, please type name

Relation to Client

(Enter address & phone # only if different from Client)

Address City, State Zip Code

Telephone

Name of Client

DOB

Client/Legal Authorized Representative Signature

Date