Client Information and Consent

Welcome and thank you for considering Winston Behavioral Healthcare PSC (“Winston Behavioral Healthcare PSC”, “WBH”, “us”, “Company”, “Corporation”) for your mental health needs. This document contains important information about our professional services and business policies.

**Counselor**

The undersigned professional is a licensed professional clinical counselor. The counselor is engaged in private practice providing mental health care services to clients directly or via licensed independent contractors of the licensed counselor’s Company. In addition, as the owner and managing shareholder, the undersigned counselor provides all mental health services through Winston Behavioral Healthcare PSC and not personally.

**Mental Health Services**

While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. The counselor, using his/her knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members to a counseling session if you feel it would be helpful or if this is recommended by your counselor.

**Appointments**

Appointments are made by calling [651-](http://xxx-xxx-xxxx)689-3007 during the normal business hours listed at [http://www.](http://www.website.com)winstonbehavioralhealth.com. Please call to cancel or reschedule at least 24 hours in advance, or you may be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments. If you are late, you will be charged for the full amount of the appointment and there will be no pro-rating of the fee. If the counselor has to cancel the appointment, you will be entitled to a refund.

**Number of Visits**

The number of sessions needed depends on many factors and will be discussed by the counselor. Your initial session will involve an evaluation of your needs and depending on your circumstances further evaluative sessions may be required. At the end of the evaluation process the undersigned counselor will be able to provide you with some first impressions of what counseling may include and a treatment plan to follow if both you and counselor agree to work together in counseling. You should evaluate this information along with your own opinions of whether you feel comfortable working with the counselor. counseling involves a large commitment of time, money, and energy, so you should be very careful about the counselor you select. If you have questions about procedures feel free to discuss them with the counselor at any time. If you have doubts your counselor will be happy to help you set up a meeting with another mental health professional for a second opinion.

**Length of Visits**

The initial intake and evaluative session is normally scheduled for one (1) hour and may run longer depending on the testing or assessments a client is asked to complete. Further evaluative sessions may be scheduled as needed for the counselor to accurately assess your needs. Once the evaluation process is completed counseling sessions are 45 to 60 minutes in length and sessions can be longer depending on the circumstances.

**Groups**

One sixty (60) minute (or longer depending on the type of group) intake session is required to determine if the group is an appropriate fit for you or your child. During the intake session you may be asked to complete one or more assessment instruments. All group sessions are 45 minutes in length and the number of sessions will vary with the type of group and the level of your participation in the group.

**Relationship**

Your relationship with the counselor is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the counselor does not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The counselor cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you.

If the counselor encounters you in public setting, in order not to reveal your identity the counselor will not acknowledge your presence unless addressed by you first.

Gifts, bartering, and trading services are not appropriate and should not be shared between you and the counselor.

**Cancellations**

Cancellations must be received at least 24 hours before your scheduled appointment; otherwise you will be charged the session fee for that missed appointment. You are responsible for calling to cancel or reschedule your appointment. Insurance generally does not cover the fee of a missed appointment.

**Payment for Services for Private Pay Patients (No Insurance)**

For services, prices range from $170 to $270 depending on the exact service and time of session. These fees are subject to change upon thirty (30) days' prior notice to you. If you are unable to pay, or are not willing to pay, the higher fee after receipt of notice, services may be terminated and you may be given referrals to other competent providers. The undersigned counselor does not normally accept assignment of insurance benefits but may be required to do so in connection with certain managed care contracts. The undersigned counselor will look to you for full payment of your account, and you will be responsible for payment of all charges. Different copayments are required by various group coverage plans. Your copayment is based on the Mental Health Policy selected by your employer or purchased by you. In addition, the copay may be different for the first visit than for subsequent visits. You are responsible for and shall pay your copay portion of the undersigned counselor's charges for services at the time the services are provided. It is recommended that you determine your copayment before your first visit by calling your benefits office or insurance company.

Although it is the goal of the undersigned counselor to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or the counselor's testimony are requested by you or required by law, regardless of who is responsible for compelling the production or testimony, you will be responsible for and shall pay the costs involved in producing the records and the hourly rate charged by the counselor at the time of the request or service of the subpoena (current rate is $250/hour) for the time involved in traveling to and from the testimony location, reviewing records and preparing to testify, waiting at the location, and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered by the counselor. The counselor may require a deposit for anticipated court appearances and preparation. You will not be entitled to a pro-rated refund for any unused portion of the deposit.

We can make no guarantee that your insurance company will provide payment for services rendered**.**

**IT IS YOUR RESPONSIBILITY TO KNOW WHAT IS AND IS NOT COVERED UNDER YOUR POLICY. YOU ARE RESPONSIBLE FOR THE FULL AMOUNT OF THE CHARGE, WHETHER OR NOT YOUR INSURANCE WILL COVER ANY PORTION.** If your insurance company requires preauthorization of services you are responsible to inform us. Be aware that some insurance companies have an annual maximum benefit for outpatient mental health coverage.

Time billed for court appearances, court case review, report writing, letters, telephone consultation, and other charges excluded by insurance coverage are your responsibility. Charges vary based on time spent and type of service.

A service charge of 1.5% (18% annual rate), or the highest statutory amount allowed, whichever is higher, will be charged on accounts past due 28 days. If payment from insurance is not received within 90 days the account may be due and payable in full by the patient. An account 90 days past due will be subject to collection procedures and/or small claims court, and the patient agrees to be held responsible for the cost disbursement, including reasonable attorneys, collection, and court fees. WBH may use the information listed below to contact you regarding your account. There is a fee of $30 for checks returned for insufficient funds. MinnesotaCare Tax will be added where applicable, and you agree to be held responsible for these fees.

**Confidentiality**

Discussions between a counselor and a client are confidential. No information will be released without the client's written consent unless mandated or permitted by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in treatment facilities; sexual exploitation; AIDS/HIV and other communicable disease infection and possible transmission; court orders; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the counselor has a duty to disclose, or where, in the counselor's judgment, it is necessary to warn, protect, notify, or disclose; sexual exploitation by a mental health professional or member of the clergy; fee disputes between the counselor and the client; a negligence suit brought by the client against the counselor; the filing of a complaint with a licensing board or other state or federal regulatory authority; to regulatory authorities in connection with their compliance or investigatory responsibilities; to employees or agents of the practice for operational purposes; to a supervisor if the counselor is under supervision and for treatment consultations with other mental health professional when deemed necessary by the counselor. FOR FURTHER INFORMATION REVIEW THE NOTICE OF PRIVACY PRACTICES FURNISHED TO YOU BY YOUR COUNSELOR IN CONJUNCTION WITH THIS CLIENT INFORMATION AND CONSENT DOCUMENT. By signing this information and consent form below you acknowledge receipt of a copy of the Notice of Privacy Practices. If you have any questions regarding confidentiality, you should bring them to the attention of the counselor when you and the counselor discuss this matter further. By signing this information and consent form below, you are giving your consent to the undersigned counselor to share confidential information with all persons mandated or permitted by law, with the agency that referred you, and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned counselor for any departure from your right of confidentiality that may result. counselors avoid conflicts of interest in treating minors or adults involved in custody or visitation actions by not performing evaluations for custody, residence, or visitation of the minor. counselors who treat minors may provide the court or mental health professional performing the evaluation with information about the minor from the counselor’s perspective as a treating counselor, so long as the counselor obtains appropriate consents to release information. The Counselor and company may release information to another counselor for the limited purpose of peer review as allowed under the professional ethics rules and standard practice rules.

**Duty to Warn**

In the event that the undersigned counselor reasonably believes that you are a danger, physically or emotionally, to yourself or another person, by signing this information and consent form below, you specifically consent for the counselor to warn the person in danger and to contact any person in position to prevent harm to yourself or another person, in addition to medical and law enforcement personnel, and the following persons if listed below at the signature block.

This information is to be provided at your request for use by said persons only to prevent harm to yourself or another person. This authorization shall expire upon the termination of your counseling with the undersigned counselor.

You acknowledge that you have the right to revoke this authorization in writing at any time to the extent the undersigned counselor has not taken action in reliance on this authorization. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned counselor that you have received and reviewed.

You acknowledge that you have been advised by the undersigned counselor of the potential of the redisclosure of your protected health information by the authorized recipients and that it may not be protected from unauthorized disclosures as required by the federal Privacy Rule.

You further acknowledge that the treatment provided to you by the undersigned counselor was conditioned on you providing this authorization.

**Mandated Reporting**

Under Minnesota Law, persons in designated professional occupations are mandated to report suspected child abuse or neglect. Persons who work with children and families are in a position to help protect children from harm. These persons are required by law to report to child protection if they know or have a reason to believe that a child is being abused or neglected or that a child has been neglected or abused within the prior three years. As a mandated reporter, the counselor may be required to break confidentiality and report certain information to the appropriate authorities.

**Risks of counseling**

You may learn things about yourself that you do not like. Often growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from counseling. Specifically, one risk of marital counseling is the possibility of exercising the divorce option. There are no guarantees in counseling and the counselor does not make any guarantees with this agreement. You assume the risk of counseling by signing this form. The counselor is not liable for any adverse reactions to counseling. The counselor may take any reasonable action necessary during counseling when there is a dangerous circumstance, as determined by the counselor.

**After-Hours Emergencies**

Please know that your counselor and Winston Behavioral Healthcare PSC do not provide twenty-four (24) hour crisis or urgent care or emergency counseling services. Should you experience an emergency necessitating immediate mental health attention, immediately call 911 or if you are able to safely transport yourself, go to the nearest hospital emergency room for assistance.

**Contacting Your counselor**

Your counselor is often not immediately available by telephone. The office number 651-689-3007 is answered by voicemail that the counselor will monitor from time to time throughout the day. Although the counselor is typically in the office during normal business hours s/he will not take calls when with a client. A reasonable effort will be made to return any call made during normal business hours on the same day it is received, weekends and holidays excepted. Messages left after hours or on weekends or holidays will normally be returned the next business day. If you are difficult to reach, please inform your counselor of times when you will be available.

**E-Mail and Text Messages**

The undersigned counselor and Winston Behavioral Healthcare PSC may use and respond to e-mail and text messages only to arrange or modify appointments. Please do not send e-mails related to your treatment or counseling sessions as electronic communications are not completely secure and confidential. Any counseling related questions or issues will not be addressed by the counselor in any electronic communication but will be dealt with during your next counseling session. Any electronic transmissions of information by you are retained in the logs of your service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. You should know that any e-mails or any communications sent via Facebook, online and specifically the website [https://winstonbehavioralhealth.com](https://winstonbehavioralhealth.com/) are not secure and you assume the risks of the insecure transmission.

**Social Media**

Your counselor does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the counselor and the client. It can blur the boundaries of the professional relationship and are not permitted. Any attempt by a client to surreptitiously gain access to the counselor's personal site(s) will be cause for termination of the counseling.

**Counselor's Incapacity or Death**

You acknowledge that, in the event the undersigned counselor becomes incapacitated or dies, it will become necessary for another counselor to take possession of your file and records. By signing this information and consent form below, you give consent to allowing another licensed mental health professional selected by the undersigned counselor to take possession of your file and records and provide you with copies upon request, or to deliver them to a counselor of your choice. The undersigned counselor will select a successor counselor within a reasonable time and will notify the appointed licensed mental health professional.

**Marital or Joint counseling**

If you participate in marital or joint counseling pursuant to which joint sessions are held with the undersigned counselor you consent for the undersigned counselor to maintain a single case file for all joint sessions and to release all information contained in the file maintained for joint sessions to any participant in the joint session upon request by a participant.

**Audio and Video Recordings**

You acknowledge and, by signing this information and consent form below, agree that neither you nor the undersigned counselor will record any part of your sessions unless you and the counselor mutually agree in writing that the session may be recorded. You further acknowledge that the undersigned counselor objects to you recording any portion of your sessions without the counselor's written consent. You expressly agree that audio and video recordings used for security purposes are not part of counseling and are therefore not protected by confidentiality or any other provisions under this agreement.

**Cooperation of Client**

You shall keep the undersigned counselor advised of your whereabouts at all times, and provide the undersigned counselor with any changes of address, phone number, contact information, or business affiliation during the time period which the undersigned counselor's services are required. You shall comply with all reasonable requests of the undersigned counselor in connection with therapeutic treatment. The undersigned counselor may set boundaries including forms of client interactions and communication including ceasing to provide services to you for good cause, including without limitation: your refusal to comply with treatment recommendations, the undersigned counselor or staff is uncomfortable working with you, or your failure to timely pay fees or deposits in accordance with this Information and Consent Form, subject to the professional responsibility requirements to which the undersigned counselor is subject. It is further understood and agreed that upon such termination of services of the undersigned counselor, any of your deposits remaining in the undersigned counselor's account shall be applied to any balance remaining owing to the undersigned counselor for fees and/or expenses and any surplus then remaining shall be refunded to you.

**Distance Counseling**

Distance counseling includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of protected health information, and education using synchronous or asynchronous audio, video, or data communications, including email. This is sometimes referred to as “Tele-medicine.”

**Identity Verification**

You may be expected to provide a copy of your driver's license and other identity verifying documentation requested by the undersigned counselor before any distance counseling services are provided.

**Privacy and Security of Communications**

All electronic communications between you and the undersigned counselor will be transmitted using reasonable measures to ensure confidentiality. You will be responsible to secure and protect the functionality, integrity, and privacy of your hardware, files, and communication. Password protection for accessing your hardware and files is recommended. If others will be accessing the same computer, be aware that programs exist that copy every keystroke you make. It is recommended that you schedule your sessions with the undersigned counselor when and where you can ensure the greatest level of privacy for all communications. Be sure to fully exit all programs and hardware at the end of each session.

**Risks Associated With Distance Counseling**

There are privacy and security risks and consequences associated with distance counseling despite the policies and procedures in place to guard against them. The risks and consequences include, but are not limited to, interrupted or distorted transmission of data or information due to technical failures and access or interception of your protected health information by unauthorized persons.

By signing this information and consent form below, you acknowledge the limitations inherent in ensuring client confidentiality of information transmitted in distance counseling and agree to waive your privilege of confidentiality with respect to any confidential information that may be accessed by an unauthorized third party despite the reasonable efforts of the undersigned counselor to arrange a secure line of communication.

Distance counseling services and care may not be as complete or effective as face-to-face services. The undersigned counselor will continually assess the appropriateness of distance counseling for you. If the undersigned counselor determines that you would be better served by receiving different therapeutic services, such as face-to-face counseling, recommendations for treatment and treatment providers or facilities will be provided to you.

**Communication Interruptions**

If you are unable to connect with the undersigned counselor or are disconnected during a session due to a technological breakdown, please try to reconnect within 5 minutes. If reconnection is not possible the undersigned counselor can be reached at the following phone number: 651-689-3007.

**Consent to Treatment Using Distance Counseling**

I, voluntarily, agree to receive synchronous (or asynchronous) assessment, care, treatment, and services through the use of email and texts and authorize the undersigned counselor to provide such care, treatment, or services as are considered necessary and advisable.

By signing this Agreement, I, the undersigned client, acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

**Conflicts of Interest**

counselors avoid conflicts of interest in treating minors or adults involved in custody or visitation actions by not performing evaluations for custody, residence, or visitation of the minor. counselors who treat minors may provide the court or mental health professional performing the evaluation with information about the minor from the counselor’s perspective as a treating counselor, so long as the counselor obtains appropriate consents to release information.

**Legal**

This Agreement shall be construed in accordance with, and governed by, the laws of the State of Minnesota as applied to contracts that are executed and performed entirely in Minnesota. The exclusive venue for any court proceeding based on or arising out of this Agreement shall be Hennepin County or Ramsey County, Minnesota. The parties agree to attempt to resolve any dispute, claim or controversy arising out of or relating to this Agreement by arbitration, which shall be conducted under the then current arbitration procedures of the American Arbitration Association any other procedure upon which the parties may agree. The parties further agree that their respective good faith participation in arbitration is a condition precedent to pursuing any other available legal or equitable remedy, including litigation, arbitration or other dispute resolution procedures. If any legal action or any arbitration or other proceeding is brought for the enforcement of this Agreement, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Agreement, the successful or prevailing party or parties shall be entitled to recover reasonable attorneys’ fees and other costs incurred in that action or proceeding, in addition to any other relief to which it or they may be entitled.

**Divorce/Custodial Situations**

The parent or guardian who brings the child in for care will be considered the responsible party and will receive all billing statements and letters. Any court-ordered financial arrangements must be worked out between the parents of the children. The parent or guardian shall pay WBH an administrative fee of $200 per hour for any administrative or legal related paperwork related to divorce or custody.

**Consent to Treatment**

I, voluntarily, agree to receive (or agree for my child to receive) Mental Health assessment, care, treatment, or services, and authorize Winston Behavioral Healthcare PSC to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care (or my child's care), treatment, or services, and that I may stop such care, treatment, or services that I receive (or my child receives) through Winston Behavioral Healthcare PSC at any time.

**By signing this Client Information and Consent form, I, the undersigned client (or parent/guardian), acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.**

**Contact Information**

You consent for the undersigned counselor to communicate with you by mail, e-mail, and by phone at the following addresses and phone numbers, and you agree to advise the counselor in the event of any change:

MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE NUMBER(S): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT / DUTY TO WARN CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Parent/Guardian 1 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian 2 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If client is a minor and parents are divorced)

as witnessed by: Agent of Winston Behavioral Healthcare PSC

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Minor Consent for Treatment Addendum (Minors presenting without parents or legal guardians only)**

Individuals under the age of 18 cannot be treated for health-related services without consent. Exceptions to this are governed by Minnesota Statutes, Chapter 144. Exceptions are summarized below and all other treatment requires parental / guardian consent. In signing below, I give the Company permission to treat my son/daughter. I may revoke this consent at any time with written notice to the Company.

**Conditions When Parental Consent Is Not Needed For Treatment of Minors**

**144.341 Living apart from parents and managing financial affairs, consent for self.**

Notwithstanding any other provision of law, any minor who is living separate and apart from parent(s) or legal guardian, whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence, and who is managing personal financial affairs, regardless of the source or extent of the minor's income, may give effective consent to personal medical, dental, mental and other health services, and the consent of no other person is required.

**144.342 Marriage or giving birth, consent for health service for self or child.**

Any minor who has been married or has borne a child may give effective consent to personal medical, mental, dental and other health services, or to services for the minor's child, and the consent of no other person is required.

**144.343 Pregnancy, venereal disease, alcohol or drug abuse, abortion.**

Any minor may give effective consent for medical, mental and other health services to determine the presence of or to treat pregnancy and conditions associated therewith, venereal disease, alcohol and other drug abuse, and the consent of no other person is required.

**144.344 Emergency treatment.**

Medical, dental, mental and other health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the professional's judgment, the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment. 144.3441 Hepatitis B vaccination. A minor may give effective consent for a hepatitis B vaccination. The consent of no other person is required.

**144.345 Representations to persons rendering service.**

The consent of a minor who claims to be able to give effective consent for the purpose of receiving medical, dental, mental or other health services but who may not in fact do so, shall be deemed effective without the consent of the minor's parent or legal guardian, if the person rendering the service relied in good faith upon the representations of the minor.

**144.346 Information to parents.**

The professional may inform the parent or legal guardian of the minor patient of any treatment given or needed where, in the judgment of the professional, failure to inform the parent or guardian would seriously jeopardize the health of the minor patient.

**144.347 Financial responsibility.**

A minor so consenting for such health services shall thereby assume financial responsibility for the cost of said services.

Minor Client Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minor Client Signature (without Legal Guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

as witnessed by: Agent of Winston Behavioral Healthcare PSC

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parental Waiver of Right to Child's Records Addendum [Optional]**

I hereby waive my right as parent/guardian to obtain information from and copies of any records from Winston Behavioral Healthcare PSC pertaining to the assessment, evaluation, and treatment of the following child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that Winston Behavioral Healthcare PSC may refuse to provide me, or any third party acting upon my request or authorization, with information and records pertaining to this child's mental health evaluation and treatment, if disclosure in the opinion of the child's counselor would negatively impact the child or the child's evaluation and treatment. I hereby release Winston Behavioral Healthcare PSC and its agents from any and all liability for good-faith refusal to disclose the child's information or records.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_