NIT BH Outpatient, After School, Summer School, and Public School Programs
Teen (Age 13-18) Client Packet 2024-2025

Name: _____
First Middle Initial Last

SSN: _____ Race: _____

☐ Nooksack Tribal Member ☐ Federally Recognized Tribal Member ☐ Non-Tribal Member

Birthdate: _____ Age: _____ Gender: ☐ Male ☐ Female ☐ Other

School Attended: _____Grade (2024): _____

Parent/Guardian Name: _____

Mailing Address: _____

Actual Address: _____

Emergency Contact Name: _____ Phone number: _____

Phone: Home: _____ Work: _____ Cell: _____

For Virtual Group Please Include:

Email: _____ Type of Device: _____

Provider One Card (Medicaid): ☐ Yes ☐ No **Must Attach Insurance Card**

Medical Insurance: _____ Policy #: _____

Primary Care Physician: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Previous Counseling? ☐ Yes ☐ No if yes, with whom and for what purpose (Name of the counselor)

_____

Signing this form also acknowledges that I consent to having my insurance billed for services rendered, and I give permission for my parent/guardian to talk to NIT Billing Dept. regarding ONLY financial affairs.

Signature: _____ **Date:** _____

Client's Rights

1. To be treated with respect and dignity.

2. To be provided professional care and services.

3. To Refuse any participation in service.

4. To receive care, which does not discriminate against me and is sensitive to my gender, race spiritual beliefs, national origin, language, age, disability and sexual orientation.

5. To be free of any sexual exploitation or harassment.

6. To review any record of service I have received with professional staff member of Nooksack Behavioral Health.

7. To receive services which we hold as completely confidential.

8. To lodge a complaint with Nooksack Health Director or Nooksack Behavioral Health Unit (Dr. Khan) if you believe your rights have been violated. A staff member from the Nooksack Behavioral Health Office may, at your request, assist you in filing a grievance.

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Informed Consent for Services

Name: _____
First MI Last

- I voluntarily consent to participate in services from the Nooksack Behavioral Health staff.
- A counselor will develop a plan aimed at improving my mental health.
- *A copy of the Client's Rights is included in this packet. If a crisis arises that is not during office hours, please* ***call 911.***
- A counselor will consult with all providers (including Medical) involved in my care in order to provide collaborative care for better outcome and keeping me safe
- My information can be used anonymously (your name will not be disclosed) for research purposes
- **Communication with my Clinician**: I understand NIT staff only use email communication and text messaging with my permission and only for administrative purposes unless we have made another agreement. Therefore, I understand no discussions of any clinical information will be exchanged by email or text, by myself or by my Clinician. Also, I understand that my clinician does not regularly check email or texts, and may not respond immediately. I understand these methods **should not** be used if there is an emergency.
- **Urgent Communication**: I understand, if I need to speak to my clinician on urgent issue I should feel free to attempt to reach my clinician by contacting the front office phone number at **360-966-2376**. I understand my clinician will try to return my call within 24 hours except on weekends and holidays.
- **Confidentiality:** I understand my clinician has a legal and ethical responsibility to make best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that no guarantee can be made where communications will be kept completely confidential or that other people may not gain access to these types of communications.
- **Technological Connection Failure**: I understand if the session is interrupted for any reason and I am having an emergency, that I will not call clinician back; and instead, I will call 911 or go to the nearest emergency room. I agree to call my clinician back after I have called or obtained emergency services.
- **Session Interrupted**: I understand if my session is interrupted and I am not having an emergency, I will disconnect from the session and wait two (2) minutes, for my clinician to re-contact me via the telepsychology platform on which we agreed to conduct therapy. I understand that if I am not contacted within two (2) minutes, then I will call the front desk phone at **(360)-966-2376**.

- **Records:** I understand the telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I understand my clinician will maintain a record of our session in the same way records have been maintained if my session was in-person in accordance with Behavioral Health policies.
- **Disclosure without consent or authorization:** Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Nooksack Behavioral Health welcomes you. We are glad we can be of service to you and look forward to working with you. If you have any questions, please feel free to call.

I have read and understand this, and my signature indicates that I agree to receive mental health services from Nooksack Behavioral Health and to participate in counseling.

Signing this form also acknowledges that I have received and read a copy of the Client Rights.

_____

Print Full Name

_____ _____

Client Signature Date

_____ _____

Counselor Name & Signature Date

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Consent to Release Confidential Information between NIT Behavioral Health After School and Public Schools

I hereby give my permission for any/all (need to know bases) information to be released between Nooksack Behavioral Health and the Tribal Youth Program, as well as my school:

(Check your school for Fall 2024)

☐ Acme Elementary
☐ Everson Elementary
☐ Nooksack Middle School
☐ Nooksack High School
☐ Harmony Elementary
☐ Nooksack Elementary
☐ Mount Baker Junior High
☐ Mount Baker High School
☐ Kendall Elementary

Any shared information between your school and Nooksack Behavioral Health will be used for the sole purpose of maintaining and improving your academic success.

Client signature (13 years and above)	Print Name	Date