BLUE VALLEY BEHAVIORAL HEALTH

Registration Consent

Client Name:

Client Case #:

- I hereby ATTEST that the information provided on the Registration form is true, complete and accurate including the information used to verify my lawful presence in the United States.
- I hereby AUTHORIZE Blue Valley Behavioral Health (BVBH) to furnish my relevant personal health information (PHI) to insurance carriers, payer sources (Region V, etc.) regulatory bodies and accrediting agencies, concerning the identified illness and treatment of myself, my legal dependents or those that I have legal and financial responsibility for. (See Notice of Privacy Practices Form)
- I hereby ASSIGN to BVBH all payments for services rendered to myself, my legal dependents and those that I have legal and financial responsibility for, named on the Registration Form. I agree to be jointly and severally responsible for all charges incurred to myself, my legal dependents and those that I have legal and financially responsibility over named on the Registration Form.
- I hereby AUTHORIZE and CONSENT for BVBH to provide behavioral health services (mental health and/or substance abuse) to myself, my legal dependents and those that I have legal and financial responsibility over.
- I hereby AUTHORIZE and CONSENT to the provision of Telehealth Services (optional) that either myself or those that I am legally responsible for will receive according to the Telehealth Patient Consent Form that was provided to me.
  __ Yes OR __ No
- I acknowledge that I have been provided with the documents listed below and agree with and understand their contents:
  - Blue Valley Behavioral Health's Client Rights and Responsibilities
  - Agency Policy
  - Notice of Privacy Practices
  - Grievance Policy
  - Financial Policy
  - Medication Notice
  - AI Documentation Platform Consent

With my signature, I agree to all of the above contents of this Registration Consent For Treatment. I understand that I may revoke this Registration Consent For Treatment in writing and submit to this local office. Any revocation of this Registration Consent for Treatment however will not cover or involve any charges, payments or services that were provided prior to this action.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

Print name of Parent/Guardian: _____

_____ _____

Witness Signature Date

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