Welcome

to the

North Texas Behavioral Health Authority

Certified Community Behavioral Health Clinic

Our collective, Certified Community Behavioral Health Clinic (CCBHC) mission is to strengthen individuals, support families, and serve communities through well-coordinated and integrated healthcare with a holistic, “no wrong door” approach providing accessible, high-quality, recovery-oriented services.

If you prefer to receive services in a language other than English, we can communicate via trained translators in more than 240 languages.

Arabic: عربي إذا كنت في حاجة إلى مترجم، أشر إلى اللغة المطلوبة	**Korean:** 한국어 통역서비스가 필요한 언어를 선택하십시오.
Bengali: বাংলা আপনার যদি একজন দোভাষীর প্রয়োজন হয়, সেক্ষেত্রে অনুগ্রহ করে আপনার ভাষা উল্লেখ করুন	**Mandarin** *(in Simplified Chinese)*: 普通话 如果您需要译员，请指向您的语言。 *(in Traditional Chinese)*: 國語 如果您需要譯員，請指向您的語言
Burmese: မြန်မာ စကားပြန်လိုရင် သင့်ဘာသာစကားကို လက်ညှိုးထိုးပြပါ။	**Nepali:** नेपाली यदि तपाईलाई दोभाषे आवश्यक परेमा, कृपया आफ्नो भाषामा संकेत गर्नुहोस्
Cantonese *(in Simplified Chinese)*: 粤语 如果您需要译员，请指向您的语言。 *(in Traditional Chinese)*: 粵語 如果您需要譯員，請指向您的語言	**Polish:** Polski Jeśli potrzebują Państwo tłumacza, proszę wskazać na swój język.
Farsi: فارسی اگر به مترجم احتیاج دارید لطفا با انگشت زبان خود را نشان دهید.	**Portuguese:** Português Se precisa de um intérprete aponte para o nome da língua que fala.
French: Français Si vous avez besoin d'un interprète, indiquez votre langue.	**Punjabi:** ਪੰਜਾਬੀ ਜੇ ਤੁਹਾਨੂੰ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਭਾਸ਼ਾ ਦਸ ਸੰਕੇਤ ਕਰੋ।
Haitian Creole: Kreyòl Ayisyen Si w bezwen yon entèprèt, montre ki lang ou pale.	**Russian:** Русский Если Вам нужен переводчик, укажите свой язык.
Italian: Italiano Se avete bisogno di un interprete, puntate alla vostra lingua.	**Somali:** Soomaali Hadaad u baahan tahay qof kuu turjuma, tilmaamo luqadaada.
Japanese: 日本語 通訳をお捜しの場合、必要な言語を指し示してください。	**Spanish:** Español Si necesita un intérprete, señale su idioma.
Karen: ကညီ နမ့်လိဉ်ဘဉ် ပှၤကတိၤကျိာ်ထံတၢ်အယိ, ဝံသးစူၤနဉ်ယီၤဆုနကျိာ်ဆိဉ်အလိ၊	**Vietnamese:** Tiếng Việt Nếu cần thông dịch viên xin hãy chỉ vào ngôn ngữ của quý vị.

Thank you for taking a first step through one of the many points of entry into our North Texas Behavioral Health Authority Certified Community Behavioral Health Clinic/System of Care. Our "no wrong door" approach is intended to remove barriers and make accessing care and services as easy as possible for you and your loved ones. It also means that, however you get connected to us, you can expect to receive continuity of care and consistently high quality across all programs and services.

Our North Texas Behavioral Health Authority Certified Community Behavioral Health Clinic's practice is to ensure that you and/or your family members receive relevant and meaningful treatment. To that end, all staff will do their best to ensure that you feel valued and that your needs are met.

Please help us get an early start toward that goal by telling us the reason for your visit. _____
_____
_____
_____
_____
_____

Please know that we want to take into consideration any past or current trauma or ***any*** event impacting you or your loved one. A thorough understanding of your life circumstances will better equip us to provide effective treatment with a focus on healing. There is space here to tell us about those experiences, but if that doesn't feel comfortable, you are encouraged to share any information you wish with a clinician at any point during your time in services with us.

_____
_____
_____
_____
_____
_____

It's also important for us to know about the symptoms people seeking services are experiencing. Please share that with us by checking all that apply to you or your loved one.

Anxiety☐ Poor Appetite☐ Worry☐ Fear☐ Panic Attacks☐ Sadness☐ Grief☐
Loneliness☐ Isolation☐ Irritability☐ Anger☐ Hearing and/or Seeing Things That Others Do Not ☐
Flashbacks☐ Mood changes☐ Changes in Sleep Habits☐ Trouble concentrating☐
Feeling Overwhelmed☐ Using drugs or alcohol to feel better☐

Do you feel like you want to hurt yourself? Yes☐ No☐
Do you feel like you want to hurt others? Yes☐ No☐

Learning a bit about your or your loved one's treatment will help us understand where to meet you in the process of recovery and will help us avoid suggesting care you've already tried, etc.

Have you received mental health treatment elsewhere? Yes☐ No☐
If yes, where? _____
If yes, most recent date: _____
If yes, for what symptoms or circumstances did you receive treatment? _____
_____

Do you or your loved one plan to return to this facility or provider? Yes☐ No☐
Have you had a psychiatric hospitalization in the last 12 months: Yes☐ No☐
If yes, what hospital? _____
If yes, most recent date: _____

List of medications you normally take:

_____
_____
_____
_____
_____
_____

Were you or your loved one referred by anyone? If so, please provide their name:

_____

Please use this space to tell us anything additional you'd like us to know. _____
_____
_____
_____
_____
_____
_____

The goal of North Texas Behavioral Health Authority Certified Community Behavioral Health Clinic Staff is to maintain an empathic, responsive attitude in all phases of care. We are dedicated to creating an environment of choice, respect, and hope. It falls within the mission of the North Texas Behavioral Health Authority Certified Community Behavioral Health Clinic to provide integrated services related to substance use, other mental health needs, and issues related to physical health to improve the success of recovery. These integrated services may include referrals to other providers when appropriate, and you can expect to be fully involved in any recommendations or decisions about your treatment. We will engage you in person-centered, family-oriented recovery planning, and your choices and preferences will be at the forefront of that process.

Your and your loved ones' wellness and quality of life are precious to us, and we are grateful you've trusted us to provide help toward your recovery.

The North Texas Behavioral Health Authority Certified Community Behavioral Health Clinic is a unified entity created by The North Texas Behavioral Health Authority (NTBHA) along with Child and Family Guidance Center (CFGC); Homeward Bound, Inc. (HWB); and Southern Area Behavioral Healthcare (SABH).

A few words about your ability to receive services from an agency of your choosing:

Individuals receiving services from our NTBHA CCBHC have the right to choose their provider. NTBHA's Care Coordinators discuss freedom of choice in all their activities, and during the screening, assessment, and diagnosis process, choice of provider will be discussed with each individual or family entering services. If specialty services are required that fall outside our scope, referrals will be made outside of the CCBHC cooperative throughout the Provider Network or to agencies with whom we have referral agreements for coordination of services.

LOCATIONS AND HOURS OF OPERATION

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY:

Administrative Offices in Dallas
(business operations only)

co-located with HWB at
Corsicana Respite House
(by appointment only)

and at
Dallas Deflection/Respite Center
(by referral or appointment only)

co-located with SABH at
Dr. Louis E. Deere Behavioral Health Complex
3001 Al Lipscomb Way
Dallas, Texas 75215
M-F 8am to 5pm

and at
The Kaufman Bridge
108 W Grove St.
Kaufman, Texas 75142
M-Th 8am to 7pm, F 8am to 5pm, Sat 8am to 12pm

Phone: 214-366-9407
Care Coordinator Referral Line: 800-241-8716
24/7 Crisis Hotline: 1-866-260-8000

CHILD AND FAMILY GUIDANCE CENTER:

8915 Harry Hines Boulevard
Dallas Texas 75235
M-F 8am to 5pm

120 West Main Street, Suite 220
Mesquite, TX 75149
M-F 8am to 5pm

4031 West Plano Pkwy, Suite 211
Plano, Texas 75093
M-F 8am to 5pm

106 South Jefferson Street
Kaufman, Texas 75142
M-Th 8am to noon and 1pm to 5pm

1505 West Jefferson Street, Suite 120
Waxahachie, Texas 75165
M-F 8am to 5pm

co-located with HWB at
319 North 12th Street, Suite 1
Corsicana, Texas 75110
M-F 8am to 5pm

Phone: 214-351-3490

HOMEWARD BOUND, INC.

2535 Lone Star Dr.
Dallas, Texas 75212
M-F 10am to 4pm

1930 E. Rosemeade Pkwy., Suite 106
Carrollton, TX 75007
M-T 1pm to 9pm, W 10am to 7pm,
Th 1pm to 9pm, F 10:30am to 6:30pm

co-located with CFGC at
319 N. 12th St., Suite 6
Corsicana, Texas 75110
M-Th 9am to 5pm

5300 University Hills Boulevard
Dallas, Texas 75241
M-F 8am to 4pm

co-located with NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY at
Corsicana Respite House (by appointment only)

and at
Dallas Deflection/Respite Center
(by referral or appointment only)

Mental Health: 214-941-3500 ext. 210
Substance Use: 214-941-3500 ext. 246

SOUTHERN AREA BEHAVIORAL HEALTHCARE:

4215 Gannon Lane
AUTHORITY at
Dallas, Texas 75237
M-F 2pm to 10pm
Sat 1pm to 7pm
Sun 2pm to 7pm

co-located with NORTH TEXAS BEHAVIORAL HEALTH

Dr. Louis E. Deere Behavioral Health Complex
3001 Al Lipscomb Way
Dallas, Texas 75215
M-F 10am to 7pm

and at
The Kaufman Bridge
110 W Grove St.
Kaufman, Texas 75142
M-F 10am to 7pm
Sat 1pm to 7pm
Sun 2pm to 7pm

Phone: 972-283-9090

GENERAL CONDITIONS OF TREATMENT

_____

Individual in Services (Last name, First name, Middle initial)

_____ _____

Date of Birth Social Security Number

CONSENT FOR SERVICES/GENERAL AGREEMENT

Authorization and consent are hereby given for the above-named person to receive outpatient mental health and/or substance use, diagnostic, and treatment services from the staff of our NTBHA CCBHC (the North Texas Behavioral Health Authority [NTBHA] along with Child and Family Guidance Center [CFGC]; Homeward Bound, Inc. [HBI]; and Southern Area Behavioral Healthcare [SABH]). It is understood that these services include an evaluation and assessment to help determine treatment or service needs via face to face and/or telemedicine. It is also acknowledged that, should services be received via telemedicine, they will be provided through video conferencing technology, and there will be a physician extender available to facilitate connectivity and any questions or concerns before, during, or after the session. The importance of providing detailed and accurate information in response to this evaluation is understood. After the evaluation and before signing the Individualized Service Plan, a detailed explanation of the proposed treatment program will be provided via the above-named person's preferred language or method. This explanation will cover the types of services that NTBHA CCBHC staff has determined would be most beneficial. In addition, any alternative treatment/services to the proposed treatment program will be presented and discussed. If there are any changes to the treatment/service program, they will be explained and consent for these changes will be sought and obtained prior to implementation. Signing below affirms the legal authority to give this consent, and the right is reserved to withdraw this authorization and consent by written notice at any time. An opportunity to review this form has been provided, and signing below confirms agreement with all the provisions contained herein. Any disagreement or reservations can be indicated by declining to provide a signature below.

_____ _____

Signature of Individual or Legally Authorized Representative (LAR) Date

_____ _____

Printed name of Individual or LAR Relationship(s) to Individual in Services

CLIENTS' RIGHTS

[THIS FORM IS TO BE GIVEN TO INDIVIDUALS TO KEEP]

The North Texas Behavioral Health Authority Certified Community Behavioral Health Clinic (NTBHA CCBHC) (the North Texas Behavioral Health Authority [NTBHA] along with Child and Family Guidance Center [CFGC]; Homeward Bound, Inc. [HBI]; and Southern Area Behavioral Healthcare [SABH]) acknowledges and protects the rights of individuals in services, which include:

- the right to impartial access to treatment, regardless of race, religion, gender, ethnicity, age, disability, or sexual orientation.
- the right to be treated in a manner that preserves and enhances their self- respect and individuality.
- the right to receive services from any provider of their choosing within the NTBHA CCBHC or the NTBHA Provider Network.
- the right to receive information necessary to give informed consent before the start of any procedure or treatment.
- the right to refuse treatment and to be informed of the consequences of such refusal.
- the right to actively participate in the development of an individualized treatment plan and to have the plan periodically reviewed. This includes the right to know and to meet with the professional staff members responsible for their care, to know their professional qualifications, and to know their staff positions.
- the right to obtain current information concerning their evaluation, treatment, and prognosis in understandable terms.
- the right to confidential treatment of their personal and medical records. Information from these sources will not be released without prior consent, except as required by law, or under third-party payment contracts.
- the right to voice opinions, recommendations, and grievances in relation to policies and services offered by the NTBHA CCBHC at any of our locations.
- the right to refuse to participate in a research program without compromising access to services to which they are otherwise entitled.
- the right to know and participate in their discharge planning and to receive appropriate referral information prior to termination of services.

Client Rights are also available in the Texas Administrative Code, Title 26, Part 1, Ch 320, Subchapter A, https://texas-sos.appianportalsgov.com/rules-and-meetings?chapter=320&interface=VIEW_TAC&part=1&subchapter=A&title=26 and the Texas Department of State Health Services' Consumer Rights Handbook can be reviewed via the link below:

https://acrobat.adobe.com/id/urn:aaid:sc:US:5de98de5-c60d-41f0-bf2c-9895988fe6e2

Both documents are also available upon request.

GRIEVANCE PROCEDURE

Clinical Services Department

The North Texas Behavioral Health Authority Certified Community Behavioral Health Clinic (NTBHA CCBHC) (the North Texas Behavioral Health Authority [NTBHA] along with Child and Family Guidance Center [CFGC]; Homeward Bound, Inc. [HBI]; and Southern Area Behavioral Healthcare [SABH]) is committed to the concerns of its clients and to receiving feedback from them. The process for a client who has a complaint or a question is to:

1. Begin by discussing the concern with your clinical provider. This will often clear up misunderstandings or simple problems.

2. If the concern is not dealt with to your satisfaction, you may speak with our *** position/title at *** telephone number or toll free at ***.

3. If the concern is still not addressed to your satisfaction, you may then contact:

***Position/Title, Name, Credentials
address
telephone number, extension

4. If the concern is still not dealt with to your satisfaction, you may then contact:

Quality Management Department
call: 833-392-4800
or in writing: email to qm@ntbha.org

or mail to:

North Texas Behavioral Health Authority
Attention: QM Department
8111 LBJ Freeway, Suite 900
Dallas, Texas 75251

1. If you prefer to provide your feedback anonymously or without direct contact with agency staff, please scan the QR Code below or go to **https://form.jotform.com/230315109399052** to complete a fillable feedback form.

* If you feel, at any time, that you have been treated unethically or your rights have been violated, you have the right to complain to the state board, which governs the professional discipline of the staff member:

Texas Medical Board 333 Guadalupe
Austin, TX 78701
(512) 305-7700

Texas Board of Nursing William P. Hobby Building 333 Guadalupe, Suite 3-460
Austin, TX 78701-3944
(512) 305-6838

Texas State Board of Examiners of Licensed Professional Counselors 100 W. 49th St.
Austin, TX 78756-3183
1-800-232-3162

Texas Board of Social Worker Examiners 1100 W. 49th St.
Austin, TX 78756-3183
1-800-232-3162

Texas Commission on Alcohol and Drug Abuse (TCADA) 9001 North I 35, Suite 105
Austin, TX 78753-5233
1-800-832-9623

U.S. Department of Disability – Americans with Disabilities Act 950 Pennsylvania Ave, NW
Civil Rights Division Disability Rights Section – NYA
Washington, D.C. 20530
202-307-0663

CLIENT RIGHTS AND GRIEVANCE PROCEDURES

I hereby acknowledge receipt of a written statement regarding my rights and responsibilities as an individual in services, which tells me how to register any complaint I might have.

This is a legal consent and assignment of benefits form. Read it carefully and ask any questions you may have prior to signing it. This consent is valid for only twelve (12) months and must be renewed annually if services continue.

_____ _____

Signature of Individual or Legally Authorized Representative (LAR) Date

_____ _____

Printed name of Individual or LAR Relationship(s) to Individual in Services

CONSENT TO PARTICIPATE IN CARE VIA TELEHEALTH

Individual's Name: _____ Date of Birth: _____

1. I hereby voluntarily consent to participate in telehealth sessions, whereby I will be receiving therapeutic and/or prescriber services via videoconferencing technology.
2. I have been informed as to how the video conferencing technology will be used to affect my care. I understand that this care will not be the same as a face-to-face interaction with my health care provider visit due to the fact that we will not be in the same room.
3. I understand that there are potential risks associated with this technology, including but not limited to interruptions, lack of audio or video, unauthorized access, and technical difficulties. I understand that I or my mental health care provider(s) can discontinue the telehealth session if one of us feels that the videoconferencing connections are not adequate for the situation.
4. I understand that, during my telehealth session, there will be a clinical extender available to me at my location in the event that I have any questions or concerns before, during, or after the session (on-site services only).
5. I understand that, at any time, if either my mental health care provider or I decide that telehealth is not the appropriate type of care for me, either my provider or I can terminate telecounseling and/or telemedicine. I understand that if my mental health care provider feels that a face-to-face appointment is necessary, I will need to come to the closest possible location for an in-person visit.
6. I understand that my express consent is required to release any healthcare information, including but not limited to information relating to testing, diagnosis, or treatment for psychiatric disorders/mental health, drug or alcohol abuse/use, HIV (AIDS virus), or sexually transmitted diseases. Should I choose to release any information to outside entities, I will do so through the standard Release of Information form provided by the North Texas Behavioral Health Authority Certified Community Behavioral Health Clinic (NTBHA CCBHC) (the North Texas Behavioral Health Authority [NTBHA] along with Child and Family Guidance Center [CFGC]; Homeward Bound, Inc. [HBI]; and Southern Area Behavioral Healthcare [SABH]).
7. I understand staff members other than the clinician may also be present during the session for the facilitation of telehealth care or technology. The above-mentioned persons will maintain the confidentiality of all information obtained. I further understand that I will be informed of their presence in the session and thus will have the right to request that non-clinical personnel leave the telehealth session.
8. I have had the alternatives to telemedicine explained to me, and in choosing to participate in a telemedicine session, I understand that some parts of the examination

involving physical tests or laboratory evaluations may be conducted by individuals at my location at the direction of my health care provider.

9. I agree that telehealth encounters may result in my Protected Health Information (PHI) being retained and used as described by federal HIPAA (Health Insurance Portability & Accountability Act) regulations. As such, various HIPAA regulations pertaining to this PHI may become applicable. I understand that the NTBHA CCBHC shall operate in accordance with all HIPAA provisions, as well as all applicable federal, state, and local laws. The interactive tele-video equipment and telecommunication lines used in sessions are HIPAA-approved for my security and privacy.
10. I understand that I can revoke this consent at any time in writing via a requested Revocation of Authorization form. I understand that a record of this revocation will be maintained in my medical record. In the event that I choose to revoke this consent, I understand that I will not be able to continue with my treatment via telehealth.
11. I have read this document carefully, or have had it read to me, and understand the risks and benefits of telehealth sessions. I have had my questions regarding the procedure explained and I hereby consent to participate in telehealth visits under the terms described.

This consent will remain in effect for 12 months from the date signed unless revoked by me in writing, whichever occurs first.

_____ OR _____

Signature of Individual in Services | Guardian or Legally Authorized Representative

_____ _____

Date | Date

HIPAA Privacy Notice

Effective: April 14, 2003

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES:

- HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
- YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
- HOW TO EXERCISE YOUR RIGHT TO GET COPIES OF YOUR RECORDS AT LIMITED COST OR, IN SOME CASES, FREE OF CHARGE
- HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION, INCLUDING YOUR RIGHT TO INSPECT OR GET COPIES OF YOUR RECORDS UNDER HIPAA. YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH NTBHA COMPLIANCE DEPARTMENT DIRECTLY AT 833-392-4800 OR VIA E-MAIL AT compliance@ntbha.org. IF YOU HAVE ANY QUESTIONS.

Please review it carefully.

When you receive treatment from the North Texas Behavioral Health Authority Certified Community Behavioral Health Clinic (NTBHA CCBHC) (the North Texas Behavioral Health Authority [NTBHA] along with Child and Family Guidance Center [CFGC]; Homeward Bound, Inc. [HBI]; and Southern Area Behavioral Healthcare [SABH]), we may generate and receive health information about you. Health information includes any information that relates to (1) your past, present, or future physical or mental health or condition, (2) providing health care to you, or (3) the past, present, or future payment for your health care.

Please note:

- We will not disclose information about you related to HIV/AIDS without your specific written permission unless the law allows us to disclose the information.
- If you are also being treated for alcohol or drug abuse, federal law protects your records and regulations found in the Code of Federal Regulations at Title 42, Part 2. Violation of these laws that protect alcohol or drug abuse treatment records is a crime, and suspected violations may be reported to appropriate authorities in accordance with federal regulations.

This notice does not apply to health information that does not identify you or anyone else. Please share this Notice with everyone in your household who receives treatment from our NTBHA CCBHC.

How Our NTBHA CCBHC Uses and Discloses Health Information

<u>Payment:</u>
Our NTBHA CCBHC may use or disclose health information about you to pay or collect payment for your health care.

Health Care Operations:

We can also use your health information for health care operations such as:

- Activities to improve health care, evaluating programs, and developing procedures.
- Case management and care coordination.
- Reviewing the competence, qualifications, performance of health care professionals and others.
- Conducting training programs and resolving internal grievances.
- Conducting accreditation, certification, licensing, or credentialing activities.
- Providing medical review, legal services, or auditing functions.
- Engaging in business planning and management or general administration.

Treatment:

We can use or disclose your health information to:

- Provide, coordinate, or manage health care or related services. This includes providing care to you, consulting with another health care provider about you, and referring you to another health care provider.
- Unless you ask us not to, we may also contact you to remind you of an appointment or to offer treatment alternatives or other health-related information that may interest you.

Family member, other relative, or close personal friend:

Our NTBHA CCBHC may release health information about you to a family member, other relative, or close friend when:

- You have agreed to the disclosure and the health information is related to that person's involvement with your care or payment for your care.
- You have a legally authorized representative (LAR) who is appointed by a court to represent your interests.

Government programs providing public benefits:

Our NTBHA CCBHC may disclose health information about you to another government agency offering public benefits if:

- The information relates to whether you qualify for services, or receive services funded by a government assistance program and the law requires or specifically allows the disclosure.

Public health:

We will disclose your health information when law or governmental regulation requires this and if directed by the public health authority.

Serious threat to health or safety:

We may use or disclose your health information to medical or law enforcement personnel if you or others are in danger and the information is necessary to prevent physical harm.

For judicial or administrative proceedings:
Our NTBHA CCBHC may disclose health information about you in response to:

- To comply with a grand jury subpoena;
- An order from a regular or administrative court; or
- A subpoena or other discovery request by a party to a lawsuit.

As required by law:
Our NTBHA CCBHC must use or disclose health information about you when a law requires the use or disclosure.

Contractors:
Our NTBHA CCBHC may disclose health information about you to our contractor(s) if the contractor:

- Needs the information to perform services for our NTBHA CCBHC and
- Agrees to protect the privacy of the information.

Secretary of Health and Human Services:
Agencies must disclose health information about you to the Secretary of Health and Human Services when the Secretary wants it to enforce privacy protections.

Research:
Our NTBHA CCBHC may use or disclose health information about you for research if information identifying you is removed from the health information.

Other uses and disclosures:
Our NTBHA CCBHC may use or disclose health information about you:

- To create health information that does not identify any specific individual;
- For purposes of lawful national security activities;
- To federal officials to protect the President and others;
- To a prison or jail, if you are an inmate of that prison or jail, or to law enforcement personnel if you are in custody so that they may provide health care to you;
- To comply with workers' compensation laws or similar laws.

Your Privacy Rights

The law gives you the right to:

1. Look at or get a copy of the health information our NTBHA CCBHC has about you, in most situations.
2. Ask our NTBHA CCBHC to correct certain information, including certain health information, if you believe the information is wrong or incomplete.
3. Ask our NTBHA CCBHC to limit the use or disclosure of health information about you more than the law requires.

4. Tell our NTBHA CCBHC where and how to send messages that include health information about you, if you think sending the information to your usual address could put you in danger. You must put this request in writing, and you must be specific about where and how to contact you.
5. Request a list of disclosures of your medical record information. This list would not include disclosures prior to April 14, 2003.
6. Ask for additional copies of this Notice from our NTBHA CCBHC (North Texas Behavioral Health Authority; Child and Family Guidance Center; Homeward Bound, Inc.; Southern Area Behavioral Healthcare).
7. Withdraw permission you have given our NTBHA CCBHC to use or disclose health information that identifies you, unless action has already been taken based on your permission. You must withdraw your permission in writing.

NTBHA CCBHC's Duty to Protect Health Information

The law requires our NTBHA CCBHC to protect the privacy of health information that identifies you. It also requires that you're given a copy of this Notice of our legal duties and privacy practices. In most situations, health information that identifies you may not be used or disclosed without your written permission. This Notice explains when our NTBHA CCBHC may use or disclose health information that identifies you without your permission.

- For all other uses and disclosures, our NTBHA CCBHC must obtain your written permission, which you may withdraw at any time.
- If our NTBHA CCBHC changes its privacy practices, it must notify you of the changes by mailing a new Privacy Notice to the most recent address you have given.
- Our NTBHA CCBHC employees are required to protect the privacy of health information that identifies you.

How to Request Copies of Your Records

You have the right to get copies of your records for a small fee or, in some cases, for free. To request your records for services received at NTBHA, CFGC, HBI, or SABH, you can fill out a Records Request Form online at this link or by using the QR code below.

If you can't access the online form, talk to a staff member. They can help you fill it out or submit it for you. You are also welcome to send an e-mail to recordsrequest@ntbha.org.

If you have questions about this Notice or need more information about your privacy rights, you may contact our NTBHA Compliance Department directly at 833-392-4800 or via e-mail at compliance@ntbha.org.

If you believe your privacy rights have been violated, you may file a complaint by contacting the:

Office for Civil Rights
U.S. Department of Health & Human Services 1301 Young Street - Suite 1169
Dallas, TX 75202
(214) 767-4056; (214) 767-8940 (TDD)
(214) 767-0432 FAX

Texas Office of the Attorney General
by mail at P.O. Box 12548, Austin, Texas, 78711-2548 or by telephone at (800) 806-2092

There will be no retaliation for filing a complaint.

_____ _____

Individual's Signature Date

_____

Legally Authorized Representative's Signature (if individual in services is a minor or assisted by a legal guardian)

_____

Representative's Relationship

AUTHORIZATION FOR DISCLOSURE, USE, OR RECEIPT OF PROTECTED HEALTH INFORMATION

(Note: For individuals receiving alcohol or drug abuse treatment, this form serves as the consent required by 42CFR §2.31.) You have the right to refuse to sign this authorization. Our North Texas Behavioral Health Authority Certified Community Behavioral Health Clinic (NTBHA CCBHC) (the North Texas Behavioral Health Authority [NTBHA] along with Child and Family Guidance Center [CFGC]; Homeward Bound, Inc. [HBI]; and Southern Area Behavioral Healthcare [SABH]) will not withhold treatment, Medicaid benefits, or payment processing if you refuse to sign this authorization.

You will receive or have access to a copy of this signed authorization.

Information about Individual Receiving Services:

Full Legal Name of Individual: _____

Individual's Date of Birth: _____

Social Security Number: _____ □ unavailable/declined to provide

Address: _____

City: _____

State: _____

Zip: _____

I authorize designated staff of the NTBHA CCBHC to □disclose/□use/□receive (check all that apply) the following written or verbal protected health information about me as described below.

☐ Psychiatrist Notes ☐ Psychotherapy Notes ☐ Lab Results

☐ Progress Note ☐ Billing Records

☐ Clinical Assessment ☐ Other _____

The facility's designated staff may □disclose/□use/□receive (check all that apply) protected health information about me □to/□from (check either or both):

_____

(name of person, organization, or facility)
The □disclose/□use/□receipt (check all that apply) is for the following purpose(s):

- □ to assist in receiving social security benefits
- □ to assist with litigation
- □ to assist with receiving services
- □ to assist in my educational placement
- □ to facilitate care coordination
- □ to coordinate my discharge
- □ planning/placement at my request
- □ other: _____

I also authorize the □disclose/□use/□receipt (check all that apply) of my health information regarding: HIV/AIDS

- □ yes
- □ no Initials: _____

and/or Alcohol or Drug Use Treatment (Note: For people getting help with alcohol or drug use, this form is the permission needed by law under 42 CFR Part 2.31)

- □ yes
- □ no Initials: _____

Please write down any limits you want to put on sharing information about your alcohol or drug use treatment. _____

_____

_____

If you are authorizing disclosure of information, the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it may no longer be protected by medical privacy laws.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and 45 CFR Parts 160 and 164 and, therefore, cannot be disclosed without my written consent unless otherwise provided for by the regulations.

If you are signing as a parent/guardian/managing conservator of a minor or as a guardian of an adult, the information disclosed/used/received may contain references about you and your family.

You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to the NTBHA CCBHC facility where you gave your authorization, which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the organization/facility, except to the extent that the organization/facility has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practices.

Unless this authorization is revoked earlier, it will expire one year from the date signed.

_____ _____

Individual's Signature Date

_____

Legally Authorized Representative's Signature (if individual in services is a minor or assisted by a legal guardian)

_____

Representative's Relationship

FINANCIAL AGREEMENT

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

In consideration of the services to be rendered to the above name individual, I hereby promise to pay for those services in accordance with the rates and terms now in effect at within the North Texas Behavioral Health Authority Certified Community Behavioral Health Clinic (NTBHA CCBHC) (the North Texas Behavioral Health Authority [NTBHA] along with Child and Family Guidance Center [CFGC]; Homeward Bound, Inc. [HBI]; and Southern Area Behavioral Healthcare [SABH]) to the extent I am legally responsible for such payment. I hereby assign to the NTBHA CCBHC any and all benefits and all interest and rights (including causes of action and the right to enforce payment) for services rendered under any insurance policies or any reimbursement or prepaid health care plan. I acknowledge that any balance not covered or paid by such policy or plan, not covered by Medicaid, Medicare or Worker's Compensation is my legal responsibility.

IF I AM A MEDICAID PATIENT

I understand that, in the opinion of the NTBHA CCBHC, the services that I have requested to be provided to the above-named individual on this date may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my/their care. I understand that the Texas Department of Human Services or its health-insuring agent determines the medical necessity of the services that I request and receive. I also understand that I am responsible for payment of the services I request and receive if these services are determined not to be reasonable and medically necessary for my care. I understand that, if I do not have insurance, financial assistance may be available through a Sliding Scale Co-Payment, if I meet the eligibility requirements and provide verification of my income.

Picture ID Verified ☐ yes ☐ no ☐ N/A (not available at time of signature)
Type of ID: _____

GUARANTY

I hereby guarantee payment of the account of the above-named individual. I further agree to pay in full the charge due at the beginning of each session unless other arrangements have been agreed to by the NTBHA CCBHC in writing. I have been told the amount due per session and understand that this amount covers only the charge for each appointment and does not include any other services or activities.

_____ _____
Signature of Guarantor Printed Name

_____ _____
Street Address City/State/Zip

FINANCIAL AND INSURANCE VERIFICATION FORM

Date:	Local Case Number:

Demographics

First Name	Middle Name	Last Name
Social Security Number	Birth Date	Gender ☐Male ☐Female ☐Non-binary ☐Intersex ☐Transgender ☐Other or Declined to Answer
Home Address	City	State
Zip Code	County	Home Phone Cell Phone
Marital Status ☐Married ☐Separated, length of separation _____ ☐Single ☐Divorced ☐Widow	Race ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White ☐More than one race ☐Unknown or Declined to Answer	Ethnicity ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Unknown or Declined to Answer

Email Address	

Emergency Contact(s) (Release of Information must be obtained for Emergency Contacts)

Name	Relationship	Contact Phone

Insurance

Plan Name	Policy Number/Group Number	Effective Date
Medicaid MCO Name:		
Medicare Part B Medicare Part D: ☐Yes ☐No		
Medicare Part C Plan Name:		
CHIP Plan Name:		
Commercial Insurance Plan Name:	Policy Number:	
Policy Holder Name:	Group Number:	
Policy Holder Relationship:	Copay/Coinsurance:	
Commercial Insurance Plan Name:	Policy Number:	
Policy Holder Name:	Group Number:	
Policy Holder Relationship:	Copay/Coinsurance:	
Veteran with VA Benefits (Has the patient served in the military and was honorably discharged?)	☐YES ☐NO	Not Applicable
NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY Eligibility **Proof of Income Received** ☐ *such as: last 2 pay stubs, Previous Year W-2, SSI/SSDI documentation, child support documentation, food stamp paperwork* **Proof of Residency Received** ☐ *such as: utility bill, Lease, Letter from shelter/temporary housing/ or VOA form* **Picture ID** ☐ *such as: Driver License, State ID, Jail ID, Military ID, Shelter-Issued ID, School ID etc.* **Proof of Insurance** ☐ *such as: copy of Insurance Card or Paperwork*	☐YES ☐NO ☐DOCUMENTS UNAVAILABLE Inability to provide any of these documents is **not** a barrier to receiving care. Services will be provided with the understanding that any necessary documentation can be provided at a later time.	Comments:

Government Assistance (Do not include as income)

Food Stamps/SNAP	
TANF	
Other	

Income (Monthly – proof required) *Household members include patient, spouse, parent/guardian, and dependents*

	Self	Household Member 2	Household Member 3	Household Member 4	Household Member 5
Gross Wages & Tips					
Retirement/Pension					
Social Security/SSI/SSDI					
Veterans					
Unemployment					
Workman's Comp					
Other (Child Support, Alimony, Trust, Interest income)					
Total					

Number in Household _____

Household members include patient, spouse, parent/guardian, and dependents.

Extraordinary Expenses (Expenses must be incurred in the last 12 months – proof required)

Major Medical Expenses	
Major Casualty/Loss	
Care of Disabled Persons	
Childcare Expenses	
Total	

Grand Total (Income minus Extraordinary Expenses)

Total	$

Ability to Pay

Maximum Monthly Fee	$

Eligibility for Other Resources (If yes list and refer for assistance)

Additional Explanation/Details

Assignment of Benefits

I request that payment of authorized insurance benefits, including Medicare, if appropriate, be made on my behalf to the NTBHA CCBHC (the North Texas Behavioral Health Authority [NTBHA] along with Child and Family Guidance Center [CFGC]; Homeward Bound, Inc. [HBI]; and Southern Area Behavioral Healthcare [SABH]) for services provided to me.	
I authorize the release of any medical or other information necessary to determine benefits or the benefits payable for related services to the NTBHA CCBHC, the Health Care Financing Administration, my insurance carrier, or other medical entity.	
A copy of this authorization may be sent to the Health Care Financing Administration, my insurance company, or other entity if requested.	
Signature:	Date:

Rights & Responsibilities

I affirm that the information provided by me is accurate and true. I understand this information will be verified and any falsification of this information could result in me being billed at the full applicable rate. I understand failure to provide all necessary documents may result in me being billed at the full applicable rate.	
I understand this information is required to be updated on a yearly basis.	
I understand the information contained in this form may be used to determine my eligibility for State funding.	
I have the right to appeal denied eligibility. I have the right to ask about this form. I have the right to review the information provided on this form. I have the right to Emergent, Medication, and initial Case Management services regardless of my ability to pay or providing complete document.	
Signature of Person Receiving Services:	Date:
Signature of Parent/Guardian/LAR (if applicable): ☐Parent of Minor☐Guardian ☐Other_____	Date:
Staff Signature:	Date:

HEALTH AND HUMAN SERVICES COMMISSION
MENTAL HEALTH MONTHLY ABILITY-TO-PAY FEE SCHEDULE FOR 2026

26 TAC, Sections 301.111 and 301.509 Effective February 12, 2026

Maximum Monthly Fee by Family Size

Annual Gross Income	Monthly Gross Income	1	2	3	4	5	6	7	8	9+	% monthly income family size 1
0 - 23,939	0 - 1,994	0	0	0	0	0	0	0	0	0	N/A
23,940	1,995	50	0	0	0	0	0	0	0	0	2.50%
26,780	2,232	59	0	0	0	0	0	0	0	0	2.66%
29,620	2,468	70	0	0	0	0	0	0	0	0	2.82%
32,460	2,705	81	50	0	0	0	0	0	0	0	2.98%
35,300	2,942	92	59	0	0	0	0	0	0	0	3.14%
38,140	3,178	105	70	0	0	0	0	0	0	0	3.30%
40,980	3,415	118	81	50	0	0	0	0	0	0	3.46%
43,820	3,652	132	92	59	0	0	0	0	0	0	3.62%
46,660	3,888	147	105	70	0	0	0	0	0	0	3.78%
49,500	4,125	163	118	81	50	0	0	0	0	0	3.94%
52,340	4,362	179	132	92	59	0	0	0	0	0	4.10%
55,180	4,598	196	147	105	70	0	0	0	0	0	4.26%
58,020	4,835	214	163	118	81	50	0	0	0	0	4.42%
60,860	5,072	232	179	132	92	59	0	0	0	0	4.58%
63,700	5,308	252	196	147	105	70	0	0	0	0	4.74%
66,540	5,545	272	214	163	118	81	50	0	0	0	4.90%
69,380	5,782	293	232	179	132	92	59	0	0	0	5.06%
72,220	6,018	314	252	196	147	105	70	0	0	0	5.22%
75,060	6,255	337	272	214	163	118	81	50	0	0	5.38%
77,900	6,492	360	293	232	179	132	92	59	0	0	5.54%
80,740	6,728	384	314	252	196	147	105	70	0	0	5.70%
83,580	6,965	408	337	272	214	163	118	81	50	0	5.86%
86,420	7,202	434	360	293	232	179	132	92	59	0	6.02%
89,260	7,438	460	384	314	252	196	147	105	70	0	6.18%
92,100	7,675	487	408	337	272	214	163	118	81	50	6.34%
94,940	7,912	514	434	360	293	232	179	132	92	59	6.50%
97,780	8,148	543	460	384	314	252	196	147	105	70	6.66%
100,620	8,385	572	487	408	337	272	214	163	118	81	6.82%
103,460	8,622	602	514	434	360	293	232	179	132	92	6.98%
106,300	8,858	632	543	460	384	314	252	196	147	105	7.14%
109,140	9,095	664	572	487	408	337	272	214	163	118	7.30%
111,980	9,332	696	602	514	434	360	293	232	179	132	7.46%
114,820	9,568	729	632	543	460	384	314	252	196	147	7.62%
117,660	9,805	763	664	572	487	408	337	272	214	163	7.78%
120,500	10,042	797	696	602	514	434	360	293	232	179	7.94%
123,340	10,278	833	729	632	543	460	384	314	252	196	8.10%
126,180	10,515	869	763	664	572	487	408	337	272	214	8.26%
129,020	10,752	905	797	696	602	514	434	360	293	232	8.42%
131,860	10,988	943	833	729	632	543	460	384	314	252	8.58%
134,700	11,225	981	869	763	664	572	487	408	337	272	8.74%
137,540	11,462	1,020	905	797	696	602	514	434	360	293	8.90%
140,380	11,698	1,060	943	833	729	632	543	460	384	314	9.06%
143,220	11,935	1,100	981	869	763	664	572	487	408	337	9.22%
146,060	12,172	1,142	1,020	905	797	696	602	514	434	360	9.38%
148,900	12,408	1,184	1,060	943	833	729	632	543	460	384	9.54%
151,740	12,645	1,227	1,100	981	869	763	664	572	487	408	9.70%
154,580	12,882	1,270	1,142	1,020	905	797	696	602	514	434	9.86%
157,420	13,118	1,314	1,184	1,060	943	833	729	632	543	460	10.02%
160,260	13,355	1,360	1,227	1,100	981	869	763	664	572	487	10.18%
163,100	13,592	1,405	1,270	1,142	1,020	905	797	696	602	514	10.34%
165,940	13,828	1,452	1,314	1,184	1,060	943	833	729	632	543	10.50%
168,780	14,065	1,499	1,360	1,227	1,100	981	869	763	664	572	10.66%
171,620	14,302	1,547	1,405	1,270	1,142	1,020	905	797	696	602	10.82%
174,460	14,538	1,596	1,452	1,314	1,184	1,060	943	833	729	632	10.98%
177,300	14,775	1,646	1,499	1,360	1,227	1,100	981	869	763	664	11.14%
180,140	15,012	1,696	1,547	1,405	1,270	1,142	1,020	905	797	696	11.30%

REVISED FEBRUARY 12, 2026

"Poverty Level – 1 Person Household"	15,960
"Additional Persons Per Household"	5,680

Source: 2026 Federal Poverty Guidelines

2.5% of monthly income at first charge for family size (FS)-1 and increasing .16% at every level. Use FS-1 amounts in each FS column beginning at 150% of FPG.

<u>To arrive at Annual Gross Income:</u>

1. Take Poverty Level * 1.5 = 1st chargeable rate	1. 15960 * 1.5 = 23940
2. Poverty level increment amount for each additional family member/2 = increments to use	2. 5680/2=2840
3. 1st chargeable rate + increments to use = Annual Gross Income	3. 23940+2840 = 26780

https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

VERIFICATION OF RECEIPT OF RIGHTS

I verify my understanding as a person receiving services or as a legal representative of a person receiving services from the NTBHA CCBHC (the North Texas Behavioral Health Authority [NTBHA] along with Child and Family Guidance Center [CFGC]; Homeward Bound, Inc. [HBI]; and Southern Area Behavioral Healthcare [SABH]). My signature means that these rights have been explained to me in simple non-technical language, that all questions have been answered to my satisfaction, and I understand my rights. This verification is valid for as long as I am a client of the NTBHA CCBHC unless information has changed, at which time an updated copy will be provided to me. Should a change occur that impacts my rights, a new verification form will need to be completed by myself or my legal representative.
The person receiving services or legal representative will initial each applicable form to indicate receipt.

Verbal	Written	N/A	
_____	_____	_____	Consent for Service / Financial Agreement
_____	_____	_____	Clients' Rights / Grievance Procedure
_____	_____	_____	Notice of Privacy Practices
_____	_____	_____	Authorization for Use & Disclosure of PHI

_____ _____
Signature of Individual in Services Date

_____ _____
Signature of Legally Authorized Representative (if required) Date

_____ _____
Signature of Staff Member Date

_____ _____
Signature of Witness (if individual is unable/unwilling to sign) Date