**ONE Health**
**4449 Easton Way, 2nd Floor, Columbus, OH 43219**
**Ph: (614) 934-1700 Fax: (855) 919-6128**

## Client Information and Acknowledgment of Informed Consent to Treatment

ONE Health practitioners, clinicians and employees will collectively be referred to throughout this consent as us, we, and ONE.

*Psychiatric Mental Health Services*

During your treatment, observations about situations will be made and help you to develop new ways to approach them, as well as prescribe appropriate medications. It will be important for you to examine your own feelings, thoughts, and behavior, and to try new approaches in order for change to occur.

The services offered can have risks as well as benefits. Treatment often involves discussing unpleasant issues, and you might experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. However, mental health care may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There might also be side effects from any medications that you will be prescribed, please report them to your treating clinician immediately if you experience them. There are no guarantees of what you will experience.

As part of this process, you will be agreeing to provide a list of all prior medications that you have been prescribed and you agree for your clinician to obtain this information via any form.

*Appointments*

Appointments are made by calling (614) 934-1700. **If you are unable to attend your appointment, you must call to cancel/reschedule at least 48 business-hours in advance as a new patient and 24 business-hours as a follow-up, or you will be charged $75.00 for the missed appointment unless determined an emergency was involved.** Any fees associated with a missed or late cancelled appointment are patient responsibility and unable to be billed to insurance. In respect for our clients, we do not double book appointments and may not be able to see a late arrival client due to time constraints and providing the appropriate level of care for each individual. In some cases, governmental insurance or employee assistance programs do not allow billing for missed or partially missed appointments and if that is the case you will be billed in accordance with those programs' rules.

*Relationship*

Our relationship with clients is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that we not have any other type of relationship with you. You always have the right to terminate services with me at any time and for any reason.

*Goals, Purposes and Techniques*

There may be alternative ways to effectively treat the concerns you are experiencing. It is important for you to discuss any questions you may have regarding your treatment recommendations and to have input into setting the goals of your therapy. You always have the opportunity to seek either another opinion or a different treating clinician during your course of treatment. You will also be made aware if your clinician feels that the relationship is not a good fit or if you might obtain better help elsewhere. Your provider will always retain the right to terminate therapy with you in the event that it is felt you would be better served elsewhere, if it is determined that you are not complying with treatment requests, or if payments due to the practice remain unpaid. In the event that the practice terminates services with you, referrals will be provided. If you do not follow-up within 3 months of your requested return to office date, the provider/patient relationship will be terminated, and you may be required to go through the process of becoming a new patient. Please note that re-establishing as a patient is subject to provider availability.

Services that may be provided, include but are not limited to: obtaining history and a physical exam, determining eligibility for treatment protocols as appropriate, managing the prescribed treatment, obtaining diagnostic tests/laboratory studies, as appropriate, the management of disease and/or treatment related health problems/effects, monitoring health status on an ongoing basis, determining nursing care and psychosocial care needs, and initiating referrals to other health care professionals as appropriate.

*Confidentiality*

Laws protect the privacy of all communications between a client and a treating clinician. In most situations we can only release information about your treatment to others if you sign a written authorization. There are some situations where we are permitted or required to disclose information either with or without your consent or authorization. For example:

- If you are involved in a court proceeding and a request is made for information concerning your treatment, we cannot provide such information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order your treating clinician to disclose information;
- If a government agency is requesting the information, we may be required to provide it;
- If you file a complaint or lawsuit against your clinician, we may disclose relevant information about you in order to defend the clinician;
- If you file a worker's compensation claim, we may be required, upon appropriate request, to provide a copy of your records, or a report of your treatment.

There are some situations in which we are legally obligated to take actions that we believe are necessary to attempt to protect others from harm, and in such cases we might have to reveal some information about your treatment. If such a situation arises, we will make every effort to fully discuss it with you before taking any action, and if deemed appropriate under the circumstances we will limit disclosure to what is necessary. For instance:

- If your treating provider has reason to believe that a child, a developmentally or physically disabled or elderly adult is being neglected or abused, the law may require us to report that information to the appropriate state or local agency;
- If your treating provider believes you to be a clear and present and substantial danger of harm to yourself and/or others, we may be obligated to take certain protective actions. This may include contacting family members, seeking hospitalization for you, notifying any potential victim(s), and/or notifying the police.

You agree that your provider may release information about your claim(s) to the Ohio Department of Insurance in connection with any insurance company's failure to properly pay a claim in a timely manner as well as to the Ohio Department of Commerce, which requires certain reporting of unclaimed funds. In those instances, only the minimal, required information will be supplied.

You agree that from time to time your treating clinician may have the need to consult with a practice attorney regarding legal issues involving your care (this is an infrequent occurrence but does happen from time to time). The practice attorney is also bound by confidentiality rules and only the information that is needed to be revealed to receive appropriate legal advice in connection with those contacts will be provided.

We are bound by HIPAA and have gone through training to protect the integrity of protected health information (PHI). As such, if there are any interactions between your treating provider and anyone else within the practice, it will be minimal information provided to assist your clinician.

Also, ONE may have a contract with a collection agency. A formal business contract with this company will be on record, in which it promises to maintain the confidentiality of this data except where release of certain information is allowed or is required by law.

In addition, ONE may have a contract with a billing service. We will have a formal HIPAA business associate contract with this business, in which it promises to maintain the confidentiality of this data except where release of certain information is allowed or is required by law.

This summary is designed to provide an overview of confidentiality and its limits. It is important that you read the Notice of Privacy Practices form that has been provided to you for more detailed explanations, and that you discuss with me any questions or concerns that you have.

*Legal Situations*

If you or the client (if the client is a minor or a ward of a guardian) become involved in legal proceedings that require your clinician's participation you will be expected to pay for all professional time, even if called to testify by another party. Your provider will ask that a retainer be paid of half of the expected fees at least one week prior to providing these services, and the second half of expected fees and any additional fees that may have been accrued be paid within one week after services are delivered. Any unused amounts will be refunded. The professional time for legal proceedings may include preparation, document review or

letter preparation, phone consultation with other professionals or you, record copying fees, and travel time to and from proceedings, testifying, and time waiting in court prior to or after your provider may be called to testify. Due to the time-consuming and often difficult nature of legal involvement, the hourly rate for these services is $400.00*. You will also be responsible for any legal fees that your clinician or ONE Health may incur in connection with the legal proceeding, which may include responding to subpoenas.

*Professional Records*

The laws and standards of psychiatry require that ONE keep Protected Health Information about you in your client file. Your client file may include information about your reasons for seeking treatment, a description of the ways in which your problems affect your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records received from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of all of your records that are prepared in connection with your treatment if you request them in writing, unless determined for clearly stated treatment reasons that disclosure of the records to you is likely to have an adverse effect on you, and in that event under Ohio law we may exercise the option of turning the records over to another mental health treating clinician, designated by you, unless otherwise required by federal law. Because these are professional records they can be misinterpreted and/or upsetting to untrained readers, therefore it is recommended that you initially review them with your clinician or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge fees set under Ohio and federal laws for copying and sending records. These fees may change every year, so we will let you know what the charge is at the time that a records request is made. If you desire to have the information sent to you electronically, we will provide the information in that format if you agree to accept the potential risks involved in sending the information that way.

A set of psychotherapy notes may be included with any medication management treatment notes, which are designed to assist in providing you with the best treatment. These notes are kept separate from the rest of your records. In order for psychotherapy notes to be released to third parties, you must sign a separate authorization in addition to one for the rest of your records. You will be informed if these notes are kept in your medical record.

*Fees, Payments, and Billing*

Payment for services is an important part of any professional relationship. This is even more true in therapy; one treatment goal is to make relationships and the duties and obligations they involve clear. You are responsible for seeing that services obtained are paid for. Meeting this responsibility shows your commitment and maturity.

A breakdown of fee schedules may be provided to you upon request and are subject to change. Service costs may vary depending on the level of complexity for your visit and are based on guidelines set forth from the Centers of Medicare and Medicaid. Debit card, credit card and check are the only approved methods of payment. Patients without insurance or who choose not to have insurance billed may be eligible for a flat fee rate.

Prescription refills: It is important for you to follow up in the time frame requested by your clinician. Medication is prescribed to provide enough coverage to get you to your next visit, however, should you need to push out your appointment/reschedule your appointment out past this date, a $25.00 fee will be assessed for filling outside of appointments.

Paperwork Fees: Any paperwork for disability, FMLA, letter writing, etc. completed outside of your office visit will be charged $25 for every 15 minutes of time. Payment will be due prior to the submission of these forms on your behalf.

Reports: You will not be charged for time spent making routine reports to your insurance company.

Testing and Off-Label Treatments: Many clinically appropriate medications, assessments and treatments are not currently FDA-approved or are considered experimental by their party payors and may not be reimbursable. The same is true for some testing, some third party payors refuse to reimburse for them. In all cases, you agree that you will be responsible for payments for these items, regardless of insurance reimbursement.

A reminder, all copayments are due on the date of service per the agreement that you have signed with your insurance carrier. If you opt to use telehealth, you are responsible for contact the office prior to your appointment to provide payment information. We strongly suggest keeping a credit card on file to avoid any administrative fees. All balances are due by the date listed on your statement or by your next visit, whichever comes first. Failure to make this payment on the date of service will result in a $5 fee assessed on top of your copayment or balance.

If you think you may have trouble paying your bills on time, please discuss this with your clinician. Payment plans should be set up within the first 30 days of your balance. We will also raise the matter with you so we can arrive at a solution. If your unpaid balance reaches $300.00, you will be notified. If your account remains unpaid, treatment may stop if an acceptable payment plan cannot be reached. Fees that continue unpaid after this may be turned over to small-claims court or a collection service.

It is important for you to know your own insurance benefits and what services are covered. Please read your plan's booklet under coverage for "Outpatient Psychotherapy" or under "Treatment of Mental and Nervous Conditions." Or call your employer's benefits office to find out what you need to know.

As a courtesy, we will file claims with any insurance company for which we are considered in-network. However, please keep some things in mind: we have no role in deciding what your insurance covers, how your benefits process or how quickly claims will process. Your employer or you (if you have individual coverage) decided which, if any, services will be covered and how much you have to pay. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, and so forth. You are responsible for paying the fees agreed upon in a timely manner. If you ask us to bill a separated spouse, a relative, or an insurance company and we do not receive payment on time, you will agree that you will be held financially responsible for covering the cost of services. In order for our office to properly bill your insurance company, we must have a copy of your updated

insurance card on file. You acknowledge that if we do not have active or updated insurance information within 90 days of your date of service, you will be required to pay for services and your account will be credited once payment is received from your insurance plan.

We will provide information about you to your insurance company with your consent, and by signing below you agree that we may do that. If we have a contract with your insurance company, then billing will be sent in accordance with the contract we have with that company. By signing this form you agree to assign any reimbursement you receive from your insurance company due to us.

If we are not contracted with your insurance company, then you may be supplied with an invoice for services with the standard diagnostic and procedure codes for billing purposes, the times met, charges, and your payments. You can use this to apply for reimbursement.

If you choose to not have us send information to your insurance company, you must select this option before each session and then pay for the session in full. We will not report any information to your insurance company about that session. Although insurance companies say that they maintain confidentiality, oftentimes they report information to a national data bank that may later affect your ability to obtain other types of insurance.

*Minors*

If you are under 18 years of age, please be aware that the law generally provides your parents the right to examine your treatment records, unless blocked by court order or if your provider feels that the release of your records to your parents might have an adverse effect on you, in which case under Ohio law they can name another mental health treating clinician that we will have to turn them over to, unless otherwise required by federal law. Before giving parents any information your provider will discuss the matter with you, if possible, and do our best to handle any objections you may have. Except in unusual circumstances, we like to make both parents aware of and involved in the treatment. In addition, if one parent brings in a child and the therapy only involves the child, under Ohio law since generally both parents have access to the child's records unless that access is blocked by a court order, anything that either parent says in the sessions is available to both parents. Legal documents need to be provided in cases where custody, visitation, shared parenting, guardianship or other matters which are covered by court documents are involved before we see a minor for treatment. Minors 14 years of age and older should be aware that they have an option to see us on a limited basis without their parents' knowledge, except where there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of our intent to inform the minor's parent, or guardian. Only the minor is responsible for paying for services under this option.

*Emergencies and After-Hours Care*

Our office phone number is 614-934-1700 and office staff is available during normal business hours to answer live calls except on scheduled holidays. We will make every effort to return messages within 24 hours; however, we may not always be able to do so, and we do not offer 24 hour per day emergency services. Current clients will be notified during sessions of upcoming travel or vacation for your clinician. Emergencies are urgent

situations that require your immediate action. If you are experiencing an emergency, particularly if you are having an adverse drug reaction, you should go directly to your nearest emergency department or call 911. The National Suicide Prevention Lifeline number is 1-800-273-8255. Netcare Access has a 24-hour answering service at 614-276-2273.

*Disclosing Information to Family Members, Relatives, or Close Friends*

_____By initialing this section you agree to allow us, if you are incapacitated, in an emergency situation, or are not available, to contact a family member, a relative, a close friend or any other person you identify, and disclose your personal health information that directly relates to that person's involvement in your healthcare. This information will be disclosed as necessary only if it is determined that it is in your best interest based on professional judgment.

*Email, Texting, and Electronic Communications*

If you decide you want to utilize any form of electronic communication you acknowledge that there are confidentiality risks inherent in such communications if they are unencrypted and you agree to accept those risks. If you wish to use unencrypted electronic communications, please place your initials in the space below:

_____By initializing this section you agree that you understand the risks involved in unencrypted electronic communications and agree to accept such risks in communications exchanges that involve scheduling and/or therapy.

Please inform the office staff or your clinician of any communication methods that are not confidential so that we may protect your privacy.

The patient portal is to be used for prescription refill requests, insurance authorization for medications, advice about minor side effects or a request for a referral for other services. **This is not an appropriate means of communication to express urgent/emergent matters, requests for medication changes, serious side effects, or worsening of symptoms.** Typical turn-around time for portal message response is 24 business hours.

*Acknowledgment of Informed Consent to Treatment*

**I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize you to provide such care, treatment or services as are considered necessary and advisable. I further authorize the submission of information to an insurance company or third party payer, to obtain reimbursement unless I direct otherwise.**

**I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through you at any time. I also understand that there are no guarantees that treatment will be successful.**

By signing this Acknowledgment of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understand all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. If a minor or an adult with a court appointed guardian is the client I am signing on behalf of the minor or ward as the authorized parent/guardian. (Information on Minor rights will be shared with the minor or the ward as appropriate.)

I also acknowledge that I have received a copy of the Notice of Privacy Practices for the mental health treating clinician listed at the top of this form.

Client Name (please print)

_____

Client Signature

_____ _____ Date

Parent(s) or Guardian Name(s) (for minor child or children or disabled adults)

_____

_____

Parent(s) or Guardian Signature(s) (for minor child or children or disabled adults)

_____ _____ Date

_____ _____ Date