Oak Hills
Behavioral Health Solutions, LLC

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660-372-1313
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CONSENT FOR TREATMENT AND TELEHEALTH POLICY

Client Name:_____

Date of Birth:_____

CLIENTS EXPERIENCING CRISIS MAY CONTACT THE 24/7 CRISIS HOTLINE: 988

I acknowledge by my signature that I have received or offered a copy of Oak Hills Behavioral Health Solutions' (OHBHS) notice of Privacy Practices located in the OHBHS waiting area. I understand that if I have any questions regarding confidentiality, I may contact the clinic Privacy Officer at (660) 372-1313. *Client's under the age of 17 years and 9 months require parental or legal guardian signature for services unless the client is in crisis or is legally emancipated.*

LIMITS OF CONFIDENTIALITY:

I understand that behavioral healthcare providers must report confirmed or suspected cases of abuse or neglect of children, elderly, and individuals who are disabled. I also understand that it is the responsibility of a behavioral healthcare provider to inform third parties or authorities if a client poses a threat to themselves or another identifiable individual.

CONFIDENTIALITY: PLEASE INITIAL HERE_____

CONDITIONS OF TREATMENT:

I understand that it is my responsibility to call the 24-hour crisis line 988 should I consider harming others or myself. I understand that when I am seen by OHBHS counselors, they may require that I receive services with a clinician/case manager as part of my treatment. Failure to honor the counselor's request may prevent me from receiving further services with OHBHS.

I agree to follow my counselor's instructions or to notify them if I am unwilling to do so. Failure to comply with treatment as mutually agreed may result in my termination from care.

I understand that my case may be closed when there are no services delivered for 60 days or more, unless I make special arrangements with my clinician for less frequent care. I further understand that I may reopen my case at any time.

CONDITIONS OF TREATMENT: PLEASE INITIAL HERE_____

APPOINTMENT NO SHOW / LATE CANCELLATION POLICY:

In order to make the most effective use of providers time and offer the most effective services to our clients the following attendance policy will strictly adhered to:

I understand that scheduling an appointment involves the reservation of time set aside especially for me. I understand that a no-show or late cancellation is considered to have occurred when the Oak Hills Behavioral Health Solutions office is not notified of a cancellation at least 24 hours in advance. In the event of an emergency, I will contact the office as soon as possible. If an appointment is canceled less than 24 hours prior or missed, I may receive an invoice for $75.00 to cover the cost of the clinician time. If I am unable to meet in person, I may request telehealth services for that appointment time in order to maintain my appointment space. Please note: Insurance does not reimburse for missed sessions.

I understand that two (2) no-shows will result in no longer being able to schedule appointments in advance. I understand that I will be restricted to call for same day available appointments only.

APPOINTMENT POLICY: Please Initial Here _____

TELEHEALTH POLICY:

I understand that telehealth involves the transmission of video, photographs and/or details of my health record. Data is sent via secure electronic means to facilitate therapeutic services. I understand that I will be informed of any other people who are present in my provider's office at the time of the telehealth session and have the right to exclude anyone of my choosing from my appointment with my provider.

I understand confidentiality protections required by law apply to my care.

I have the right to refuse or stop telehealth services at any time. I understand that equivalent in person services may not be available at the same time or location as telehealth services. If I refuse telehealth services, it will not affect my right to future care or treatment.

TELEHEALTH CONSENT: PLEASE INITIAL HERE_____

FEE FOR SERVICE POLICY:

I understand that there may be fees for my service and that payment is required at the time of service.

I understand that reduced fee services are only available to those qualifying both clinically and financially.

I understand that if I fail to pay for services received, that not only may my services be terminated, but in addition, all billing information including name, address, place of employment, dates of service(s) received, etc., may be given to a professional collection agency to use in their process of collections. I further understand that if my account is placed in collections, I will be responsible for the fee charged by the collection agency and any attorney or court fees assessed.

FEES FOR SERVICE: PLEASE INITIAL HERE _____

INSURANCE BENEFITS AND REASSIGNMENT POLICY AND RELEASE:

I understand that it is my responsibility to know and understand my insurance benefits, including copayments, deductibles and covered providers. I understand that if my deductibles are not met that I am responsible for the contracted rate that would be paid by my insurance company until such time that my deductible and out of pocket requirements are met.

I hereby authorize my insurance benefits to be paid directly to Oak Hills Behavioral Health Solutions, LLC and I recognize my responsibility to pay for all non-covered services, including any additional cost incurred in collecting these amounts. I also authorize Oak Hills Behavioral Health Solutions LLC to release any and all information regarding pre-admission data (this excludes third party information), assessments, diagnosis, prognosis and treatment for physical and or emotional illness, including treatment of alcohol and drug use to any and all of my insurance companies or their legal representatives for the the policies that I have in force during the dates of my treatment. Any such disclosure shall be limited to information that is reasonably necessary to legal or contractual obligations of the insurance companies.

INSURANCE BENEFITS POLICY AND RELEASE: PLEASE INITIAL HERE_____

RELEASE OF LIABILITY ON AUTHORIZED RELEASES OR INFORMATION

I am aware that this authorization constitutes a waiver of all claims against Oak Hills Behavioral Health Solutions, it's agents, servants, or employees as a result of their compliance with this authorization, ande that neither Oak Hills Behavioral Health Solutions nor any of it's agents, servants or employees will have any responsibility for the acts of the recipients of this information with respect to said records, after they are made available as I have authorized and requested.

CLIENT RIGHTS AND GRIEVANCE PROCEDURES:

I have received or been offered a statement of my rights as a client of Oak HIlls Behavioral Health Solutions, LLC, including proper grievance procedures should I be dissatisfied with any of the policies and procedures or my treatment at Oak Hills Behavioral Health Solutions, LLC. I understand that as a client of OHBHS I am entitled to the following rights and privileges:

1. To receive prompt evaluation, care and treatment;
2. To receive these services in a least restrictive environment;
3. To receive these services in a clean and safe setting;
4. To not be denied admission of services because of race, gender, sexual preference, marital status, national origin, disability or age;
5. To confidentiality of information and records in accordance with federal and state laws and regulation;
6. To be treated with dignity and addressed in a respectful, age appropriate manner;
7. To be free from abuse, neglect, physical punishment and other mistreatment such as humiliation, threats or exploitation;
8. To be the subject of and experiment or research only with my informed consent, or the consent of the person legally authorized to act on my behalf;
9. To the extent that the facilities, equipment, and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice;
10. To refuse treatment unless ordered by the court or authorized by my guardian, except in an a emergency;
11. To consult with a private practitioner at my own expense.

CONSENT FOR SMS

I give consent for text reminders. I understand there may be fees incurred for receipt of texts depending on my phone plan.

CONSENT FOR TEXT: PLEASE INITIAL HERE _____

CONSENT FOR TREATMENT AND FOLLOW-UP

I understand all the preceding statements and will adhere to these policies during my services with Oak Hills Behavioral Health Solutions, LLC. I am requesting the services of Oak Hills Behavioral Health Solutions, LLC and agree to be contacted by a facility representative during or after my services to ascertain the results of my treatment and my satisfaction with the services that I received through Oak Hills Behavioral Health Solutions, LLC.

I understand that Oak Hills Behavioral Health Solutions, LLC services as a clinical training site for mental health professionals with advanced degrees that have not yet obtained full licensure. In some cases, these individuals may be part of the care that I receive, and my participation is closely monitored and supervised by a fully licensed professional. I have the right to decline the participation of these individuals from my care by informing the front desk or admissions staff of

these decisions. Oak HIlls Behavioral Solutions, LLC considers the training of tomorrow's professionals an important mission along with providing quality healthcare services to me.

Signature of Client /Guardian:_____Date:_____

OHBHS Witness: _____Date: _____