THE BEHAVIORAL WELLNESS GROUP

8224 Mentor Ave #208, Mentor, OH 44060 • 110 Traders Cross, Bluffton SC 29909 • 2375 East Camelback Rd #600, Phoenix, AZ 85016
Phone: 888-996-9374 Fax: 440-565-2349
www.behavioralwellnessgroup.com

PATIENT INFORMATION

Date _____ DOB ____/____/_____ Age ____ ☐Male ☐Female

Name _____ SSN _____

Email _____ May We Include You in our Email Newsletter? ☐Yes ☐No

Phone _____ _____ _____
(Home) (Cell) (Work)

Address_____
(Street)

_____ _____ _____
(City) (State) (Zip Code)

If You Found Us Online, What Did You Search: _____

Who Referred You _____

May we contact your referral source? ☐Yes ☐No Phone _____Fax_____

May we contact your primary care physician? ☐Yes ☐No

Physician Name _____ Phone Number _____Fax Number _____

Marital Status _____ Student? ☐Yes ☐No

Parent /Guardian _____Phone _____
(If Applicable)

Primary Insurance Company _____ Phone _____

Mental Health Carrier_____ Phone_____
(If Different from Primary Insurance Company)

Name of Policy Holder_____ Policy Holder DOB ____/____/_____

Address of Policy Holder _____

Phone number of Policy Holder _____

SSN of Policy Holder_____ Relationship to Patient_____

Member I.D./Subscriber # _____Group # _____Employer_____

Authorization # _____ Co-Pay $_____ Deductible $_____

Emergency Contact _____ _____ _____
(Name) (Phone Number) (Relationship to Patient)

Pharmacy Name _____ Phone _____

Physician Address _____

May we: Contact you by phone to remind you of an appointment? ☐Yes ☐No Leave you a voice mail message? ☐Yes ☐No

PLEASE COMPLETE REVERSE SIDE

PROFESSIONAL SERVICES AGREEMENT

I understand that the effectiveness of mental health services depends on efforts of the patient as well as those of the practitioner (Clinician) and I promise to make my best effort to comply with these procedures. These best efforts will include open and honest discussion of my thoughts and feelings, as well as an effort to perform any exercises or homework assignments that may be recommended. I also agree to return, undamaged, any materials that have been loaned to me as part of the procedures and understand that I am liable for the cost of these materials. I understand that the effectiveness of the procedures cannot be guaranteed and that the Clinician has sole professional responsibility for all services provided.

I understand that regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so, I will notify the Clinician at least two weeks in advance so that effective planning for continued care can be implemented. I also agree to notify the Clinician at least 24 business hours in advance if I will be unable to attend any session. I understand that if I fail to make such notification, I may be charged for the full cost of the session, which will not be reimbursable by my insurance company. I agree to be responsible for these charges.

I understand that conversations with the Clinician will be of a confidential nature. I authorize my Clinician to discuss my treatment with other treatment providers to coordinate my care. I further understand that the Clinician, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the Clinician has a legal responsibility to protect anyone that the patient may threaten with violence, harmful or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. I understand that the Clinician will make reasonable efforts to resolve these situations before breaking confidentiality. I also understand that in order to ensure patient confidentiality and privacy, electronic recording is strictly prohibited within any of The Behavioral Wellness Group's offices.

I understand that prescribed medication can only be provided in coordination with regular office visits, in order to provide me with safe and appropriate medical care, and that any urgent requests by me for medication refills without an office visit will incur a $25 administrative fee, non- reimbursable by insurance.

My signature below indicates that I have agreed to these terms and have read and understand a "Notice of Privacy Practices" and a "Welcome to our Practice" informational flyer describing my rights and responsibilities as a patient or guardian.

_____ _____

(Signature of Patient or Guardian) **(Date)**

FINANCIAL AGREEMENT

Patients are responsible for providing accurate information about their insurance benefits. Failure to complete this section or inaccurate information will make patients fully responsible for all charges. Patients are responsible for notifying The Behavioral Wellness Group of any changes in insurance within 30 days; otherwise, you will be responsible for payment in full. In most cases, patients are responsible for making the initial phone call to their insurance companies. The Behavioral Wellness Group does not bill secondary insurance, including Medicaid and its subsidiaries.

I request that The Behavioral Wellness Group, as the agent for the Clinician, submit bills to the insurance company that I have listed above on this form, and I grant permission to the Clinician and The Behavioral Wellness Group to release such confidential information as is necessary to obtain payment from the insurance company. In the event that my insurance company fails to observe Ohio prompt pay standards or otherwise fails to adhere to relevant rules and standards, I grant permission to The Behavioral Wellness Group to share information related to my insurance claim with the Ohio Department of Insurance.

I understand that I am financially responsible for the cost of the mental health services to me (my child) and for any portion of the fees not reimbursed or covered by my health insurance. I understand that my copay is due at time of service, otherwise a $10 billing fee will be charged each time for any bill that is sent if I have an outstanding patient balance. If my mental health care is provided under the terms and conditions of a managed mental health care program to which the Clinician is contracted, my financial responsibilities may be limited by the terms of that contract. I understand that my failure to pay these bills may result in collection procedures (including court proceedings) being taken against me by the Clinician or a collection agency contracted by the Clinician to collect these bills. I also understand that if my account is placed in collection procedures, neither I nor any other patient of The Behavioral Wellness Group for whom I am the guarantor will be able to schedule appointments with any other Behavioral Wellness Group clinician.

I understand that professional services will be rendered to me by_____ (Clinician) and that the fee for a 30-50 minute initial consultation session will be $_____ and the fee for follow-up appointments will be $_____ along with fees for any testing materials. I authorize the release of any medical information necessary to process my claim. Fees may be different for additional services such as psychological testing, legal consultation/testimony, report preparation, consultations with others on my behalf, phone/e-sessions etc. and will be explained to me if these services are necessary.

My signature below indicates that I have agreed to the above terms.

_____ _____

(Signature of Patient or Guardian) **(Date)**

FINANCIAL RESPONSIBILITY (if other than patient)

Name _____ ☐**Male** ☐**Female** **DOB** ____/____/_____

Address (If Different from Patient) _____ **SSN**_____

_____ **Phone**_____

Signature of Financially Responsible Party _____ **Date** _____

☐***ID Verified*** _____ ***(Staff Use Only)***

BWG MEDICAL SERVICES POLICIES AND PROCEDURES

PATIENT STATEMENT OF UNDERSTANDING

The choice to begin treatment is an important decision. Thank you for placing your confidence in BWG and your provider. In order to facilitate the process, we have created some guidelines below. Please note that in our commitment to assisting you with your treatment goals, we welcome open discussion about your treatment and progress throughout this process.

POLICY:

It is the policy of The Behavioral Wellness Group (BWG) to provide access to medications that support the maximum functioning of the persons served while reducing specific symptoms and minimizing the impact of side effects, as well as to monitor the use of controlled substances.
The Ohio Automated Rx Reporting System (OARRS), a tool to track the dispensing and personal furnishing of controlled prescription drugs to patients, will be used by BWG.
To ensure this policy is fully realized, The Behavioral Wellness Group will enhance services through detailed and comprehensive Pharmacotherapy policies and procedures.

PROCEDURES:

INITIAL APPOINTMENTS: Initial appointments range from 60 to 120 minutes depending on the provider.

FOLLOW-UP APPOINTMENTS: Follow-up appointments range from 15 to 45 minutes.

MEDICATION MANAGEMENT: Medication may be prescribed as part of the treatment. Emotional and physical effects to be expected will be explained. Please call Medical Services if you experience any unexpected changes. Services are occasionally provided in addition to the regularly scheduled medication appointments. These might include consulting with other physicians or therapists, telephone consultations, providing reports, or completing forms for referral sources, insurance companies, and attorneys. The fees for these professional services range from $25 to $280.00, depending on the service code.

- New patient (including Self pay) $310.00
- Follow-up (including Self pay) $200.00
- No Show/Late Cancel Fee $85.00
- Prescription Fee $25.00
- Paperwork Fee (depending on length/time) $25.00 - $50.00

All persons receiving medications will be required to have a regularly scheduled visit with their prescriber, as determined by the prescriber.

The Behavioral Wellness Group will ensure that all persons served receive optimal pharmacotherapy services and monitoring of **controlled substances**.

You will always be provided with prescriptions for enough medication to last until your next appointment. If an error appears to have been made, please contact the office **directly** as electronic prescription requests from pharmacies and refill requests called in/faxed by a pharmacy will not be honored.

If those regularly scheduled visits are not kept and a medication refill is called in to BWG Medical Services:

- that medication will be refilled for a fee of $25
- a follow-up appointment will be scheduled
- only sufficient medication to last until that follow-up appointment will be provided
- please note that refills include any/all medications **EXCEPT** controlled substance, as these will **NOT** be refilled between office visits

NO SHOWS/LATE CANCELLATIONS:
A full 24 business hours' notice is required for cancellations
Payments for late cancels/no-shows will be expected at or before the next scheduled appointment. If you have an emergency and must cancel, please speak with your prescriber directly about the possibility of negating the charge prior to the cancellation. THE PATIENT, NOT THE INSURANCE COMPANY, WILL BE RESPONSIBLE FOR PAYING FOR APPOINTMENTS CANCELED WITH LESS THAN **24** BUSINESS HOURS NOTICE. By signing this Patient Statement of Understanding, you agree to pay for any missed appointments via check or credit card.

TELEPHONE HOURS: Medical Services office hours are 9:00am to 4:00pm, Monday through Thursday and 9:00am to 3:30pm Fridays. Voice mail messages will be returned as soon as possible, generally within **72 business hours**.

EMERGENCIES: For extreme emergencies such as: self-destructive intent, alcohol or drug intoxication, severe medication reactions or loss of contact with reality, **call 911 or go to the nearest emergency room immediately.**

URGENT ISSUES: For after-hours urgent issues such as medication side effects, please leave a message for Medical Services. Medication refills are not emergency or urgent issues.

TESTS AND PRESCRIPTIONS: Special tests are sometimes necessary to help diagnose psychological or medical disorders or to help determine whether an emotional problem has physical elements or a physical cause. The use of certain medications will require periodic blood tests. Most medication issues require a face-to-face evaluation. Refills of prescriptions will be issued at the time of your follow-up visit

"PRIVATE PAY" PATIENTS: Fees are generally based upon the length of time of a session. While some insurance companies reimburse the patient for psychiatric care, the payment of the bill is the patient's responsibility. Please make full payment at the time of each appointment. If you have insurance that will reimburse you, submit a copy of your receipt and bill to the insurance company for reimbursement.

PAYMENTS / "CONTRACTED" INSURANCE: If we are a contracted provider with your insurance carrier, BWG staff will submit the charges for services and accept payment by that company. Any self-pay, contracted deductible, co-payment, coinsurance or partial payment that is the insured's responsibility will be collected at the time of service.

BILLING: For billing issues, contact Kathy Long at 330-523-7231.

CONFIDENTIALITY: Your accumulated medical records are confidential except under special legal circumstances. Information contained in them will not be released to anyone without written consent from you, the patient. Please ask me if you have any questions.

TERMINATION OF CARE: Termination of care may occur by mutual consent, completion of treatment, or for your failure to keep your appointments or pay for services. If you do not contact your prescriber for more than three months and make no follow-up appointments, your care will be terminated unless you have made verbal arrangements for continuation of your treatment with your BWG prescriber.

CONFIDENTIALITY: To protect your confidentiality, if our paths cross outside of this office, I will not initiate contact with you.

_____

I have read and understand the above policy **Date**

Revised 8.13.19
Revised 8.17.20
Revised 9.09.20
Revised 10.31.22
Revised 12.14.22

www.behavioralwellnessgroup.com
www.campustherapy.com

REQUESTANDAUTHORIZATION TO RELEASE RECORDSAND INFORMATION

I, _____, born on _____, authorize _____

Patient Name (print)
Clinician Name

☐ **To Release/Disclose To:** ☐ **To Obtain Information From:**

Name _____Relationship to Patient_____

Address _____

_____

Phone Fax

This information is for treatment planning and ongoing care. If for other reasons, please describe:

_____

This authorization includes release of records relating to:

☐ Mental Health
☐ Chemical Dependency Abuse Treatment
☐ HIV/AIDS
☐ Diagnoses and/or treatment relating to other communicable diseases

This authorization and request to release or obtain information from my records is fully understood as to the nature of the records and information and the implications of its release, and is made voluntarily on my part. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. In addition, if this information is redisclosed by the recipient, it will also not be protected by federal privacy regulations.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I further understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I have been informed that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will expire automatically 90 days after the last billed session.

_____ _____ _____

Signature of Patient or Parent/Guardian Date Relationship to Patient

_____ _____ Identification Verified ☐

Signature of Witness Date **(Staff Use Only)**

___ Revoke Previous Authorization

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PSYCHIATRIC AND MEDICAL HISTORY

If any item below does not apply, please enter N/A

Client Information

Patient Name:_____ DOB: _____

Marital Status: □ Married □ Single Preferred Pronouns: _____

Employer:_____ or School: _____

Language Preference:_____ Reading Level: _____

Last Grade Completed:_____ Degree Earned: _____

Military Service? □ Yes □ No Branch: _____ Type of Discharge:_____

Social History

City of Residence:_____ Do you live with anyone? □ Yes □ No

With Whom?_____ Status of environment? □ Abuse □ Neglect

Support:

□ Spouse
□ Partner
□ Nuclear Family
□ Extended Family
□ Other
□ Close Friend
□ Group of Friends
□ Church/Mosque/Temple/Support Group
□ Service System

Religious Affiliation? □ Yes □ No Importance of faith in your life (scale of 1-10):_____

Prior/Current criminal record? □ Yes □ No Currently working with attorney? □ Yes □ No

If yes, please explain:_____

Current Issues/Family History

Why are you seeking therapy or medication management at this time?_____

_____

What is happening that makes this problematic? _____

What are your goals for therapy/treatment? _____

If you are currently in a relationship, which of the following problems, if any, do you have with your partner (please check those that apply)

□ Conflict about money	□ Conflict about friends	□ Conflict about religious beliefs
□ Conflict about sex	□ Conflict about time together	□ Other
□ Conflict about employment	□ Conflict about spouse's family	
□ Conflict about stepchildren	□ Conflict about lifestyle	
□ Conflict about children	□ Conflict about substance use	

Family of Origin/Children

Parents/Siblings/Guardians	Age	Level of Contact 1-5 (1=distant, 5=close)	Living (L) Deceased (D)

Children	Age	Level of Contact 1-5 (1=distant, 5=close)	Living (L) Deceased (D)

Medical History

Have you experienced any of the following? (please check those that apply):

□ Alcoholism	□ Chronic Pain	□ Headaches	□ Smoking
□ Allergies	□ Degenerative Disease	□ Head Injury(ies)	□ Thyroid Issues
□ Arthritis	□ Diabetes	□ Hearing Problems	□ Tremors
□ Asthma	□ Drug Addiction	□ Hormonal Issues	□ Vision Problems
□ Cancer	□ Epilepsy	□ Hypertension	□ Other
□ Chest Pain	□ Fainting	□ Obesity	

If other please list: _____

Pain level for above conditions (1-10)? _____ Type of pain? _____
(throbbing, aching, etc.)

Any Hospitalizations (Medical or Psychiatric) in the past 3 years? □ Yes □ No Reason: _____

_____

_____

_____

Are you pregnant? □ Yes □ No Need for prenatal care? □ Yes □ No

Medications

Medication/Dosage	Purpose	Prescribing Doctor

Previous Psychiatric Medication/Dosage	Purpose	Prescribing Doctor

Please list drug allergies: _____

Do you smoke Nicotine? □ Yes □ No How much? _____

Psychiatric History

Past Counselor/Psychiatrists	Dates of Treatment

Family Member Psychiatric History	Diagnosis

Substance Use/Abuse History

Substance	Quantity	Frequency	Period of Time	Date of last use

Any Previous Suicide Attempts? □ Yes □ No

Nutritional History

Do you eat 2 meals or less per day? □ Yes □ No How many?_____

Do you follow a special diet due to illness? □ Yes □ No Please Specify:_____

_____

History of binging/purging/restricting/etc? □ Yes □ No Please Specify:_____

_____

Do you eat fast food more than 2x/week? □ Yes □ No How often? _____

Other

Is there anything else you would like your clinician/provider to know about you? _____

_____

_____

_____

_____

_____

_____

_____

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AUTHORIZATION FOR ELECTRONIC COMMUNICATION

_____consent to engage in telehealth with
(**Name of Client**)

_____. I understand that "telehealth" includes
(**Name of Clinician**)

consultation, treatment, transfer of medical data, emails, and telephone conversations using HIPAA compliant, interactive audio, video, and/or data communications. I understand that telehealth also involves the communication of my medical and/or mental health information, both orally and visually.

I understand that I have the following rights with respect to telehealth:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of treatment is generally confidential. However, there are mandatory and permissive exceptions to confidentiality which include:
    a. Disclosure of child abuse, neglect or endangerment
    b. Disclosure of elder abuse, neglect or endangerment
    c. Disclosure of imminent danger to myself or toward others

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility that the transmission of my information could be disrupted or distorted by technical failures. Other unlikely events may include interruptions by unauthorized persons—despite reasonable efforts taken by The Behavioral Wellness Group. Should this occur, The Behavioral Wellness Group has an emergency plan in place to abruptly end the session to protect the therapeutic relationship. I may then choose to have telephonic communication if the session was by audiovisual means.

4. I will make every effort to be as timely as possible for my telehealth appointment. I understand that my provider will make every effort to start as timely as possible and that at times, delays will be inevitable especially given unexpected emergent situations. In the event that my provider is not present within 15 minutes of my telehealth appointment, they will make every effort to get a message to me that they are running late if at all possible. In the event that I am not present within 15 minutes of my telehealth appointment, I will make every effort to get a message to my provider that I am running late if at all possible.

5. Should services be disrupted, The Behavioral Wellness Group will attempt to contact you at the earliest possible convenience. Also, further appropriateness of telehealth sessions will be discussed.

6. My Clinician will respond to communications within 48 business hours.

7. For other communication, it is requested that treatment services and related issues be limited to face-to-face visits, telehealth and video chatting only and that sessions are scheduled in advance. Emails, faxes, texts, etc. may be used for Administrative purposes and simple questions only.

8. I understand that if The Behavioral Wellness Group believes I would be better served by another form of treatment services (e.g. face-to-face), I will be referred to a professional in my practice or in the geographical area that can provide such services. I understand that an appointment may not be immediately available. Also, I understand that there are potential risks and benefits associated with any form of treatment services and that my condition may or may not improve. Thus, results cannot be guaranteed/assured.

9. Insurance coverage for telehealth varies. **It is important to ask your insurance company ahead of time** about whether they would cover telehealth services in your case. Our billing specialist can help with this. If you are paying for telehealth sessions "out-of-pocket," The Behavioral Wellness Group's policy is that out-of-pocket services be paid either before or at the time of service.

10. My Provider may utilize alternative means of communication in the following circumstances: Billing and Administrative issues which will be handled by Provider along with other BWG Staff such as Office and Medical Assistants and Billing Specialist using means of communication most appropriate at the time.

11. I accept that telehealth does not provide emergency services. During the evaluation, an emergency response plan will be discussed. If I am experiencing an emergency situation, including but not limited to a self-harming circumstance, I agree to call 911, 440-953-TALK / text NAMI to 741-741 or proceed to my nearest emergency room for immediate help. This may be done for me involuntarily if my Provider believes I am of imminent harm to myself or others.

12. I understand that I am responsible for:
    a. Providing necessary telecommunications equipment and internet access for my telehealth sessions
    b. The information security on my computer
    c. Arranging a location with sufficient lighting and privacy free from distractions or intrusions

13. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state laws.

14. I will take precautions to ensure that my communications are directed only to my Provider or other appropriate individuals.

15. I understand that I will be informed of the identities of all people who are present during the telehealth session and informed of their purpose for attending the session.

16. I understand that my Provider may abruptly end the session if I am acting inappropriately.

17. I understand that BWG uses a HIPAA compliant "non-public facing" communications platform. BWG and my provider will make every effort to protect my privacy, and I understand that they will be held harmless should my information be compromised as a result of something out of their control.

18. I understand that Audio/Visual telehealth sessions will be provided via HIPAA compliant connections through our HIPAA compliant EMR, or via the HIPAA compliant version of the platform itself.

19. My communications exchanged with my Provider will be stored using TherapyAppointment, a HIPAA compliant software program.

20. I understand that this Telehealth Informed Consent is an addendum to our Standard Informed Consent and does not replace it in any manner. All aspects of that Standard Informed Consent shall remain in effect.

21. I understand that my Provider will reinforce the importance of compliance with all of the above by me, my Provider, BWG.

22. I understand that my telehealth provider will ask where I am located for the telehealth session and that the location will be documented in the session note.

23. In the event of an emergency, the name and number of my local hospital is listed below:

Name of Hospital **Phone Number of Hospital**

24. If I am not in my local area, the nearest hospital/phone number will be shared with my provider, and it will be documented in my session note.

I have read, understand, and agree to the information provided above.

Client/Guardian's Signature **Date**

Printed Name

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5.09.2022
01.09.2024