THE BEHAVIORAL WELLNESS GROUP
8224 Mentor Ave #208, Mentor, OH 44060 • 55-A Sheridan Park Circle, Bluffton, SC 29910
2375 East Camelback Rd #600, Phoenix, AZ 85016 • 230 Horizon Drive, Unit 101B, Verona, WI 53593
Toll Free: 888 996 9374 • Office: 440 392 2222 • Fax: 440 565 2349
www.behavioralwellnessgroup.com

PATIENT INFORMATION

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

Name _____ **Preferred Pronouns**_____

Email _____ **May we leave message on voicemail?** ☐ **Yes** ☐ **No**

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

Address_____
(Street)

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

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

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 _____

Relationship to Patient_____

Member I.D./Subscriber # _____Group # _____Employer_____

Authorization # _____ Co-Pay $_____ Deductible $_____

Pharmacy Name _____ Phone _____

Physician Address _____

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** ☐ **Other** _____

Address (If Different from Patient) _____ **Date of Birth**_____

_____ **Phone**_____

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

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

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PSYCHIATRIC AND MEDICAL HISTORY

Patient's Name: _____ Date: _____

SOCIAL HISTORY/CLIENT INFORMATION

In what city do you live? _____

Do you live with anyone? ☐ YES ☐ NO

If yes, with whom? _____

Please list occupation inside/outside of home. _____

_____

If employed, current employment and length of time on job. _____

_____

Please state the last grade you completed or last degree earned. _____

Please state, if any, military service. _____

Dates: _____

Are you currently working with an attorney on any legal matters? ☐ YES ☐ NO

If yes, explain. _____

_____

Please list previous felonies/misdemeanors/legal issues: _____

_____

Please rate the importance of religion/faith in your life on a scale of 10.

0-not important; 10-very important _____

Religious Affiliation: Present _____ Past _____

Please list your hobbies/interests. _____

_____

Are you: (Check one): ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Please answer the following:

Have you ever felt like you should cut down on your alcohol or drug use (including prescription drugs)?	☐ YES	☐ NO
Has a friend or relative discussed concerns about your use?	☐ YES	☐ NO
Have you ever felt guilty about your drinking or drug use?	☐ YES	☐ NO
Have you ever had to take a drink or use a drug the next day to steady your nerves?	☐ YES	☐ NO
Are you a recovering alcoholic or recovering drug addict?	☐ YES	☐ NO
Have there been problems with alcohol or drug use your family?	☐ YES	☐ NO

MEDICAL HISTORY

Have you experienced either currently or in the past any of the following:

Past	Now		Past	Now		Past	Now	
		Arthritis			Headaches			Allergies
		Asthma			Cancer			Chest Pain
		Diabetes			Epilepsy			Fainting
		Hormones			Hypertension			Tremors
		Alcoholism			Thyroid			Obesity
		Chronic Pain			Smoking			Hearing
		Vision			Head Injury			Drug Addiction
		Degenerative Disease			Drug Reactions to:			
		Other, please identify						

Please list current medications and dose, if known.

Medication	Dosage	Purpose	Physician Prescribing

List all allergies to medication and reaction (rash, breathing problem, hives, etc.)

Medication	Reaction

Do your smoke cigarettes ☐ YES ☐ NO If so how much:_____

PSYCHIATRIC HISTORY

Please list the names of past/present psychiatric counselors, therapists, psychiatrists, and duration of treatment.

_____

_____

_____

Please list previous psychiatric diagnosis, if known: _____

_____

Please list all previous psychiatric medications you have tried:

Please list any previous suicide attempts (method and date):

Have you ever been hospitalized for a psychiatric conditions? ☐ YES ☐ NO

If yes, please explain: _____

_____

_____

_____

FAMILY HISTORY

Do you have any family members with a psychiatric history? ☐ YES ☐ NO

If yes please explain: _____

_____

_____

_____

Have any family members committed suicide? ☐ YES ☐ NO

If yes, please explain: _____

_____

Growing up did you experience verbal, physical or sexual abuse? ☐ YES ☐ NO

If yes, please explain: _____

_____

_____

_____

CURRENT ISSUES

Check the items that describe or relate to your concerns:

☐	Family Violence	☐	Bereavement	☐	Anger Management
☐	Depression	☐	Anxiety/Nervous	☐	Guilt
☐	Religious Doubts or Fears	☐	Marriage Problems	☐	Sexual Concerns
☐	Affairs	☐	Relationship with Parents	☐	Relationship with Children
☐	Suicidal Thoughts/Feelings	☐	Loneliness	☐	Fears/Phobias
☐	Drug/Alcohol Abuse	☐	Financial Difficulties	☐	Legal Problems
☐	Attention/Concentration	☐	Loss of Love or Hope	☐	Lack of Confidence
☐	Irritability or Impatience	☐	Mood Swings	☐	Disturbing Thoughts
☐	Eating/Sleeping Problems	☐	Employment/School Problems	☐	Tension/Pressure of Stress

What brings you to counseling at this time? _____

_____

_____

_____

MARITAL HISTORY

	Name	Date Married	Date Separated	Date Divorced	Date Widowed
1st					
2nd					
3rd					

If not married, have you or are you living intimately with another person? ☐ YES ☐ NO

Names and ages of children in order of birth:

Name	Sex	Age	Date of Birth	Deceased/Date

FAMILY BACKGROUND

	Name	Living	Age	Deceased/Date
Father				
Mother				
Stepfather				
Stepmother				

Brothers and sisters. From oldest to the youngest (including yourself).

Name	Age	Male/Female	Self	Deceased/Date

FOR OFFICE USE ONLY

Axis I:		
Axis II:		
Axis III:		
Axis IV:		
Axis V:	Current	Highest

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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

Revised: 9.28.2020
5.09.2022
01.09.2024
10.29.2024

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CREDIT CARD AUTHORIZATION FORM

DATE: _____PATIENT NAME: _____

CARDHOLDER NAME: _____Zip Code _____

CARD NUMBER (LAST 4 NUMBERS): _____Visa M/C Disc AmEx EXP. DATE: _____

SECURITY CODE (ON BACK) _____

The Behavioral Wellness Group has my authorization to charge my card for balances not covered by insurance and for which I am personally responsible.

I hereby authorize The Behavioral Wellness Group to keep my debit or credit card or bank account information (as indicated above) on file for payment and to **initiate appropriate payment entries against the above referenced debit or credit card or bank account, as applicable, as amounts are owed by me on the Patient Account listed above**. I acknowledge that the initiation of all such entries to make payments on the Patient Account listed above must comply with the provisions of U.S. law and any applicable state laws. I understand and agree that these entries may be made to my debit or credit card or bank account, as applicable, periodically to pay amounts owed by me on the Patient Account listed above. I also agree to notify The Behavioral Wellness Group if my debit or credit card, or bank account information (as indicated above) changes for any reason. This authorization shall remain in effect until the "End date of authorization" listed above or until I communicate to The Behavioral Wellness Group my intention to cancel this authorization by calling The Behavioral Wellness Group at (440) 392-2222 or writing to The Behavioral Wellness Group at 8224 Mentor Ave. #208 Mentor OH 44060. **In the event of a returned ACH or a declined charge, my account will be charged a $10.00 service fee for each occurrence**. I acknowledge receipt of a copy of this authorization form.

_☐_ I do not need notice prior to assessing my card

_☐_I wish to be given 24-hour notice prior to assessing my card via

(*select only one*)

_☐_phone call at the following number: _____

_☐_ email at the following email address _____

CARDHOLDER SIGNATURE: _____

*Please note credit cards are processed under the name of **Cayan**.*

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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

HIPAA Notice of Privacy Practices

Effective Date*: *June 29 2022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Dr. John Glovan at 440-392-2222 ext. 302 or jglovan@behavioralwellnessgroup.com.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your signed permission. You may revoke such permission at any time by contacting our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR SIGNED AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your signed authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your signed authorization. If you do give us an authorization, you may revoke it at any time by submitting a signed revocation to your individual clinician and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Dr. John Glovan, Psy.D. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must submit a signed request to your individual clinician.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided signed authorization. To request an accounting of disclosures, you must make your request, in writing, to your individual clinician.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse/family member. To request a restriction, you must submit a signed request to your individual clinician. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will

comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by email or at work. To request confidential communications, you must submit a signed request to your individual clinician. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.behavioralwellnessgroup.com. To obtain a paper copy of this notice, please print it from our website or ask your individual clinician.

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Dr. John Glovan, Psy.D (if your service provider is Dr. Glovan , please submit complaints to Michael Pollak, PCC-S, LICDC). You may find Grievance/Satisfaction/Suggestion Forms in our Facility Suggestion Box and at www.behavioralwellnessgroup.com

All complaints must be made in writing. **You will not be penalized for filing a complaint**.

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.

The Behavioral
WELLNESS GROUP

GLOVAN, POLLAK AND ASSOCIATES, LLC

8224 Mentor Ave. #208 Mentor OH 44060
Phone: 440-392-2222 Fax: 440-565-2349

BEHAVIORAL HEALTH RIGHTS AND RESPONSIBILITIES

STATEMENT OF RIGHTS:

- To be treated with consideration, respect, and dignity at all times.
- To receive timely and competent mental health services.
- To have privacy when undertaking treatment.
- To maintain confidentiality of records and all information, unless released with signed permission.
- To be fully informed about presenting problems, diagnosis, treatment plans, and to register acknowledgment of participation in formulating a treatment plan.
- To make choices about the length of treatment and participation in treatment and research activities.
- To be referred to other treatment providers if needed or dissatisfied.
- To be treated in an environment free from financial/other exploitation, abuse, neglect; without fears of retaliation or humiliation

THE INDIVIDUAL'S RESPONSIBILITIES:

- The individual participates to the extent possible or desired in the development of treatment plan and subsequent changes.
- The individual has the responsibility to notify their clinician when scheduled visits cannot be kept—minimum of 24 hours in advance.
- The individual has the responsibility for supplying accurate and complete information regarding medical history and mental health history.
- The individual is responsible for his/her action if the treatment plan is not followed.
- The individual is responsible to notify the clinician if instructions are not understood or cannot be followed.
- The individual is responsible to behave appropriately and safely or the clinician may terminate the session or contact the appropriate authorities to ensure safety.
- Persons served have the responsibility to attend services without the use of contraband to include alcohol, illicit drugs and weapons.
- Persons served have the responsibility to follow all of The Behavioral Wellness Group's rules and regulations, safety rules and posted signs.

QUESTIONS OR COMPLAINTS:

At The Behavioral Wellness Group, we strive to provide quality services. If you believe your privacy rights have been violated, need assistance or have a question/complaint/suggestion, please speak to your clinician. If you remain dissatisfied or have feedback, you may find Grievance/Satisfaction/Suggestion Forms in our Facility Suggestion Box and at www.behavioralwellnessgroup.com. Please place them in the Facility Suggestion Box or email them to:

John A. Glovan, Psy.D.
Privacy Officer/Managing Director
Glovan, Pollak and Associates LLC
jglovan@behavioralwellnessgroup.com

If Treating Clinician is Dr. Glovan, Then Contact:
Michael Pollak, PCC-S, LICDC
Managing Member
mpollak@behavioralwellnessgroup.com

You may also submit a complaint to the Secretary of the Department of Health and Human Services.

BWG 6/29/22