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:** ○ **He/Him** ○ **She/Her** ○ **They/Them** ○ **Other:**_____

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

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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

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5.09.2022
01.09.2024
10.29.2024