UBHS
UNITED BEHAVIORAL HEALTH SOLUTIONS
2900 Chamblee Tucker Rd, Bldg 16 - Atlanta, GA 30341
Phone: 770-939-1288 Fax: 770-212-2203

Consent for Treatment

The mental health provider/patient framework helps to create the safety to take risks and the support to become empowered to changes. As our client, you have certain rights that are important for you to know. There are also certain legal limitations to those rights. As a psychiatric practice, we have corresponding responsibilities to you.

Confidentiality: Outside of the certain specific exceptions described below, you have the absolute right to the confidentiality of your sessions. In general, the law and ethics of our profession protect the confidentiality of all communications between a client and his/her provider and the provider may only release information about the sessions to others with your written permission. However, there are certain legal exceptions to confidentiality. They are as follows: your mental health practitioner will inform you any time it becomes necessary to invoke one of these exceptions.

- If your provider has good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give him/her information about someone else who is doing this, your provider is required by law to file a report with the appropriate state agency.
- If, in the professional judgment of your provider, he/she believes that you are threatening serious harm to another person, your provider is required to take protective action. This may include notifying the police, warning the intended victim, warning other members of the intended victim's family or associates, or seeking the client's hospitalization.
- If a client threatens to harm him/herself, your provider is required to take protective action, which may include: hospitalization for the client, contacting family or support resources, or referring the client for further evaluation.

The clear intent of these requirements is that mental health providers have both a legal and ethical responsibility to take action to protect endangered individuals from harm when in their professional judgment such danger exists.

Be aware that addressing feelings or thoughts that you have not confronted in the past may be painful. Making changes in your beliefs and behaviors can be scary, and sometimes disruptive to the relationships in your life. It is important to consider carefully whether these risks are worth the benefits to your changing. Most people who take these risks find that psychiatric treatment is helpful, and your provider will do what he/she can to help minimize risks and maximize positive outcomes.

I understand that if I leave services at UBHS, that UBHS is not committed to sending medication if I am unable to find a new provider.

I understand that my initial visit does not automatically mean/imply that UBHS providers are assuming the responsibility of my ongoing psychiatric treatment and may refer me out to a more

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appropriate treatment setting. I also understand that if progress in treatment is not met, UBHS may terminate services with no more than thirty days' worth of medication while I secure a new provider.

I also understand that open and honest communication about my medication is vital to my treatment and that UBHS may access through electronic means all medication I am currently prescribed and failure to disclose all medications or substance use may result in termination of services.

I understand if the patient is a minor child, a parent or legal guardian must be present for all appointments. I also understand that in the event of custody arrangements, it is my responsibility to share with UBHS the outline of those arrangements otherwise both legal parents/guardians have a right to access the patient's records.

In the course of some medication treatments for psychiatric conditions, providers may feel a drug screen panel is warranted. I understand that if drug screens are requested, failure to submit to one is considered a positive screen. UBHS uses a 12 panel test cup and the charge is $20 if my insurance does not pay for drug screens. Also note, that drug screens are purely for treatment coordination and care and positive results not reported to legal authorities outside of any mandated child welfare reporting.

Client Consent: I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand my rights and responsibilities as a client, and my mental health provider's responsibilities to me. I know I can end treatment at any time I wish and that I can refuse any requests or suggestions made by my provider. I am over the age of eighteen or am the parent or legal guardian signing on behalf of a minor child or impaired adult.

Patient Name: _____

Patient Signature:_____ Date: _____

If Applicable:

Legal Guardian's/Representative Name**:** _____

Relationship to Patient: _____

Legal Guardian/Representative Signature: Date:

_____ _____

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Consent to Bill

I understand and agree that I am financially responsible for all charges for any and all services rendered.

If my insurance is accepted, I authorize payment of benefits to UBHS, Inc or will reimburse UBHC, Inc if I am paid directly by my carrier.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent.

Print Name of Patient, Authorized Representative or Responsible Party

_____

Patient, Authorized Representative or Responsible Party Signature

_____

Date

_____

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GEORGIA HIPAA NOTICE

HIPAA is a federal law that provides privacy protections and assures patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a complete printed copy of the Georgia HIPAA Notice for use and disclosure of PHI for treatment, payment and health care operations. The Georgia HIPAA Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that I have provided you with this information. We can discuss any questions that you may have about the procedures outlined in the Georgia HIPAA Notice.

Notice of Psychiatrist's Policies and Practices to Protect the Privacy of Your Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Georgia State Laws.

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION UNDER THE NEW HIPPA LAWS. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations:

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

• "PHI" refers to information in your health record that could identify you.
• "Treatment, Payment and Health Care Operations" is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
• "Payment" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
• "Health Care Operations" are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
• "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
• "Disclosure" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

• Serious Threat to Health or Safety – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.
• Child Abuse – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
• Adult and Domestic Abuse – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.
• Health Oversight – If I am the subject of an inquiry by the Georgia Board of Psychological Examiners, I may be required to disclose protected health information regarding you in proceedings before the Board.
• Judicial or Administrative Proceedings – If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
• Worker's Compensation – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

• Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
• Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
• Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. An appointment will be scheduled to review these records in my presence so that any issues can be discussed. Normal hourly and/or copying changes will apply. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
• Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. Upon your request, I will discuss with you the details of the amendment process.
• Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. Upon your request, I will discuss with you the details of the accounting process.
• Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request.
Psychologist's Duties:
• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
• I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
• If I revise my policies and procedures, I will notify you at the mailing address you provided.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me at 2900 Chamblee Tucker Road, Building 16 Atlanta, GA 30341 Phone (770)939-1288 Fax (770) 212-2203

GA 30312. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Restrictions
I will limit the uses or disclosures that I will make as follows:
• I will not release the contents of "Psychotherapy Notes" under any circumstance with the following exceptions:
• If you file a lawsuit or ethics complaint against me, I may release "Psychotherapy Notes" for use in my defense.
• When the following "Uses and Disclosures with "Neither Consent nor Authorization" apply:
• Child Abuse
• Adult and Domestic Abuse
• Health Oversight
• Judicial or Administrative Proceedings
• Serious Threat to Health or Safety

I have read, understand, and agree to abide by the terms and conditions set forth in the Georgia HIPAA Notice, and do hereby consent to participation in the treatment as described in the consent agreement. I also understand taht my participation is entirely voluntary, and that I may withdrawl my consent and terminate treatment at any time.

Print Name of Patient

Signature and Date

Telehealth Consent Form

PATIENT NAME: _____

DATE OF BIRTH: _____

INSURANCE ID#: _____

1. **PURPOSE**: The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with the following procedure(s) and/or service(s):

   Behavioral Health Medication Management

2. **NATURE OF TELEHEALTH CONSULT**: During the telehealth consultation:

   a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
   d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)

3. **MEDICAL INFORMATION & RECORDS**: All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient- identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.

4. **CONFIDENTIALITY**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telehealth consultation.

5. **RIGHTS:** You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. **DISPUTES**: You agree that any dispute arriving from the telehealth consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.

7. **RISKS, CONSEQUENCES & BENEFITS**: You have been advised of all the potential risks, consequences and benefits of telehealth. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telehealth consultation for the procedure(s) described above.

Signature: _____ Date: _____

If signed by someone other than the patient, indicate relationship: _____

Witness Signature: _____ Date: _____

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United Behavioral Health Solutions, Inc. Policy

Office Policies and Guidelines: The information in this packet pertains to the treatment and financial polices of United Behavioral Health Solutions, Inc. Please read the packet in its entirety and be sure to sign the agreement at the end of the packet so that we know you understand and acknowledge all guidelines and policies for UBHS.

Your Privacy/Confidentiality: Communication between you and your doctor is considered **privileged and confidential. We will not release any information without your written release.** The billing information we give to your insurance carrier provides only information about the dates of service, diagnosis, and procedure codes. The only exception to these conditions may occur in situations such as child abuse, danger to life or workers ' compensation where by law other action is permitted. Please discuss this with your doctor/therapist.

Disclosure of information to anyone such as another doctor, an attorney and/or a family member must be requested by written authorization by the patient. In an emergency situation when you, the patient, are at imminent risk of death or serious medical consequence, your physician will release minimal, critically relevant information to assist in preventing dire medical consequences that may result if that relevant information is not released. In the case of a minor, their legal guardian must sign the authorization. The physician is legally bound to break doctor-patient confidentiality in cases of threat of harm to self or others and in reports of child or geriatric abuse.

Office Hours: The office staff is usually **available from 9:00am-5:00pm Monday through Thursday**. When the office staff is not available, please leave a voicemail message and we will return your call at the earliest possible time. The first priority and our primary concern is your well being. In an emergency, please go to the nearest hospital emergency room (ER) for help with your problem.

Appointments: Appointments are scheduled with your convenience in mind. The availability of the physician is often limited and it is important to remember your appointment is reserved for you. If unable to attend your reserved appointment, you are expected to give **24 hours notice** with a staff member. Failure to do so will result in a broken appointment fee of $25.00. Your insurance company will not cover this fee. It is your responsibility.

Appointment Length: Appointments are billed on the basis of 15 increments. If an appointment runs longer then the appointed time, you will be charged for the additional time spent with our provider. The charge will be determined and prorated on the basis of each additional 15 minutes of time.

Cancellations: We ask that any cancellations of appointments be made **at least 24 hours prior** to the scheduled session. In the event that our office is not notified in advance, the patient will be responsible for the broken appointment fee of $25 unless other arrangements are made with the office staff.

Payment Fees: The patient, or legal guardian is financially responsible for the total cost of services rendered and payment is expected at the time of service. Those paying with insurance are expected to pay co-pays at the time of service. If you are unable to pay for your service (self-pay or co-pay), you will be asked to reschedule for another time. If this happens more than once, you will also be charged a $25.00 for cancellation appointment fee. Also, a service fee of **$50.00** will be charged for all returned checks.

INSURANCES ACCEPTED: Medicaid (AMERIGROUP, Wellcare, Cenpatico), CIGNA, HUMANA, MEDICARE and TRI-CARE

SELF-PAY RATES: Patients who do not have insurance or elect to pay directly for services provided by United Behavioral Health Solutions, will be billed at the following rates:

INITIAL EVALUATION: $250

FOLLOW-UP(UP TO 20): $125 , FOLLOW-UP (25-45 MINS): $180

PAYMENT TYPES ACCEPTED FOR OFFICE VISITS:

VISA, MASTERCARD, CASH, CASHIER'S CHECK

Phone calls: Emergency calls are handled as a priority. If you are having an emergency of a medical nature, please call 911 immediately. Routine calls will be handled by the office staff for your situation. Calls that require the doctor to review information will be handled as timely as possible. Please leave a phone number and a time span of when you will be available for a return call. If possible, please call during business hours, 9:00am-5:00pm, Monday-Friday.

Medication Refills: We handle all refills during your regular scheduled appointments. If a medication refill becomes necessary, please provide us with your pharmacy phone number, medication name, and how you are currently taking your medication. We will require you to schedule an appointment with the physician then call in enough medication (non-controlled medications) to last until your appointment. We appreciate your cooperation in keeping track of your medication supply in order to avoid running out. Allow 24-48 hours for telephone prescriptions. We do not accept fax requests from your pharmacy. You need to contact our office directly for new prescriptions or refills. There is a $25 fee for medication refill requests between appointments.

Maintaining Patient Status: In our area of healthcare, it is very important that you be seen on a regular basis. At the end of each appointment, your physician will tell you how long a period of time he would like you to schedule a follow-up appointment in the office. We urge you to make the follow-up appointment before you leave our office in order to schedule the most convenient time for you. If you fail to keep and/or maintain follow-up appointments for a period of 120 days or greater, we will conclude that you have terminated the patient-physician relationship.

Medical Reports/Correspondence: Disability forms, work excuses, calls to employers, return to work letters, etc. will be provided on a fee basis. The fee must be prepaid in order for us to complete the requested task. The fee will be based on time spent preparing the requested information.

I have read and understood the policies as stated above.

Patient Name: _____

Patient Signature: _____

If patient is a minor,

Parent or Guardian Name: _____

Parent or Guardian Signature: _____

Date Signed: _____

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Patient Information Form

Please complete this information and note that all information provided is protected as confidential in accordance with HIPAA.

Full Legal Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: (we will use this for appointment reminders) _____-_____-_____

☐ Please check if this is a cell phone and if we may send text reminders for appointments

Email Address: _____
Note this will be used to access our patient portal and for confidential exchange of information

Gender Identity: ☐Male ☐Female ☐Prefers to not disclose SSN: _____

Primary Physician's Name, Address, and Phone: _____

Do you give permission for ongoing regular updates to be provided to your primary care physician? ☐Y ☐N

Current Therapist/Counselor: _____ Therapist's Phone: _____

Preferred Pharmacy: _____

Primary Insurance:

_____
Name of Insurance Member Number Group Number

Primary Insurance Member/Provider Services Phone Number: _____

Secondary Insurance:

_____
Name of Insurance Member Number Group Number

What are the problem(s) for which you are seeking help?
1._____
2._____
3._____

Allergies: _____ ☐ NKDA

Height: _____ Weight: _____

Other persons living in your home:

Name	Relationship	Age

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Please list any other medications you are currently taking (include any for medical or psychiatric purposes)

Medical Condition	Medication	Dose/Frequency	Prescriber

Current Symptoms Checklist:

☐Depressed mood
☐Unable to enjoy activities
☐Sleep pattern disturbance
☐Loss of interest
☐Concentration/forgetfulness
☐Change in appetite
☐Increased irritability
☐Decreased libido
☐Racing thoughts
☐Impulsivity
☐Increase risky behavior
☐Increased libido
☐Decrease need for sleep
☐Excessive energy
☐Fatigue
☐Suicidal thoughts
☐Excessive worry
☐Anxiety attacks
☐Avoidance
☐Hallucinations
☐Suspiciousness
☐Excessive guilt
☐Crying spells
☐Homicidal thoughts

Please check any that apply:

☐Family history of substance abuse _____

☐Family history of mental health issues _____

☐Family history of domestic violence _____

☐Hospitalization in the past two years for psychiatric concerns _____

Please know the following questions are asked with respect to your privacy and we ask that you answer honestly knowing that your provider is not in judgment of any answer but will use this information only for the coordination of care and in selecting the best medication regime for treatment if necessary.

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No
If yes, for which substances? _____
If yes, where were you treated and when? _____
_____
How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
Have you used any street drugs in the past 3 months? ☐ Yes ☐ No
If yes, which ones? _____
Have you ever abused prescription medication? ☐ Yes ☐ No
If yes, which ones and for how long? _____

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Check if you have ever tried the following:

	Y	N	If yes, how long and when did you last use?
Marijuana	☐	☐	_____
Cocaine	☐	☐	_____
Heroin	☐	☐	_____
Opiates (prescription)	☐	☐	_____
Ecstatsy	☐	☐	_____
Meth-amphetamine	☐	☐	_____
Suboxone	☐	☐	_____
Other	☐	☐	_____

For Child and Adolescent Patients Only:

School Name: _____

Current Grade Level: _____

Please select type of curriculum:

☐General ☐Alternative ☐504 plan ☐IEP

List any learning disabilities or issues that may be affecting behaviors:

_____

_____

Any history of abuse (physical, sexual, emotional)? Any history of out of home placement (foster care, guardianship, group home, RYDC)?

_____

_____

_____

Signature_____Date_____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Relationship_____ Phone: _____