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**OAK HILLS BEHAVIORAL HEALTH SOLUTIONS, LLC
(OHBHS)
OHBHS POLICY AND CONSENT FOR TREATMENT**

Client Name: _____

Date of Birth: _____

Mental Health Crisis Hotline 988

Carefully read the entire document before signing. Initials at the end of each section indicate that you have read and understood the information.

*Clients under the age of 17 years and nine months require parental legal guardian signature for service unless the client is in crisis or is legally emancipated.

1. Limits of confidentiality

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

Initial for limits of confidentiality: _____

2. Conditions of treatment

I understand that it is my responsibility to call the 24 hour crisis line 988 should I consider harming myself or others. If the emergency involves an adverse reaction, allergic response, or drug/medication related poisoning, I will call 911 for a medical emergency.

I understand that when I am seen by an OHBHS provider they may require that I receive additional services such as case management as part of my treatment. Failure to honor providers' reasonable requests may prevent me from receiving additional services with OHBHS. I agree to follow my provider's instructions or to discuss it with them if I am unwilling to do so. Failure to comply with treatment as mutually agreed-upon may result in termination of services.

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

Initial for conditions of treatment: _____

3. Appointment no-show late cancel policy

OHBHS strives to provide services to a number of individuals so we strictly adhere to the attendance policy outlined below:

I understand that scheduling an appointment involves the reservation of time set aside especially for me. I understand that a no-show or late cancellation is considered to have occurred when the OHBHS office has not been notified of intent to cancel at least 24 hours in

advance. In an emergency, I will contact the office as soon as possible. If an appointment is canceled less than 24 hours in advance, I may receive an invoice for \$75 to cover the cost of the clinicians time. If I am unable to meet in person I may request telehealth services for that appointment time to maintain my appointment space. Please note: **insurance does not reimburse for missed sessions**. I understand the two no-shows will result in no longer being able to schedule appointments in advance. I understand that I will be restricted to call for same day available appointments only. _____

4. Telehealth policy and Use of AI assisted technology

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

I understand that telehealth confidentiality protections required by law apply to me and I may stop telehealth services at any time. I understand that equivalent in person services may not be available at the same time or location as telehealth services. If I refuse telehealth services it will not affect my right to future care or treatment.

I understand that my provider may use AI platforms such as UpHeal, Scribe, or other platforms specifically designed for healthcare to record sessions and assist in generating documentation. AI platforms used by my provider are compliant with HIPAA and SOC 2 requirements and meet federal guidelines for my security and privacy. Clinicians who use these platforms will review the documents for accuracy before finalizing the notation. I understand that recordings of sessions are strictly for note generation and will be erased after the note is generated.

Initial for telehealth and AI assisted technology use: _____

5. Fee for service policy

I understand that there may be fees for my services and payment is required at the time of service. I understand the reduced fee services are only available to those who qualify clinically and financially.

I understand that some services provided by OHBHS are not covered by insurance. These fees are due in advance of the service and include:

Secure Electronic Transmission of clinical records: \$35 per event

Letters written on your behalf: \$75 per event

Documentation completed on your behalf (excluding work/school notes) \$75 per event

Search, retrieval, and review of clinical records: \$27.46

Physical copy of your clinical records: \$0.63 per page

Travel time and appearance for court OR phone interview/affidavit: \$150 per hour

Mileage: \$0.67 per mile

I understand if I fail to pay for services that I have received OHBHS my services may be terminated but all billing information including name address, employment dates of service and so forth may be provided to a professional collection agency to use in the process of collection.

In addition if my account is placed in collections I understand that I will be responsible for any and all fees charged by the collection agency and or attorney your court fees as assessed.

Initial for fee for service:_____

6. Insurance benefits and reassignment policy and release

I understand that it is my responsibility to know and understand by insurance benefits including copayment deductibles and cover providers. I understand that if my deductible has not been met that I am responsible for the contracted rate that would be paid by my insurance company until the time that my deductible has been met and any and all out-of-pocket requirements have been met.

I authorize my insurance benefits to be paid directly to OHBHS and I recognize my responsibility to pay for all non-covered services including any additional amount incurred including the amount due. I also authorize OHBHS to release any and all information regarding pre-admission data (excluding third-party information) assessments, diagnosis, prognosis, and treatment for physical, mental illness, and treatment of alcohol and drug use to any and all of my insurance companies or their legal representatives for the policies I have in force during the dates of treatment. Any such disclosure will be limited to information that is reasonably necessary for legal or contractual obligations to the insurance company.

Initial for insurance benefits, reassignment, and release:_____

7. Release of liability on authorized releases or information

I am aware that this authorization constitutes a waiver of all claims against OHBHS agency contractors, servants, or employees as a result of their compliance with this authorization, and neither Oak Hills Behavioral Health Solutions, LLC, or any of its agents, servants, employees or contractors will have any responsibility for the action of the recipients of this information with respect to send records after they have been made available as I have authorized and requested.

Initial for release of liability authorized release of information:_____

8. Client rights and grievances procedures

I have received or been offered a statement of my rights as a client of OHBHS. This includes proper grievance procedures should I be dissatisfied with any of the policies and procedures for my treatments at OHBHS.

I understand that as client of OHBHS I am entitled to the following rights and privileges:

- receive prompt assessment care and treatment.
- receive services in the least restrictive environment.
- To receive the services in a clean and safe setting.
- Not to be denied admission of services because of race gender sexual preferences marital status national origin disability or age.
- confidentiality of information and records in accordance with federal and state laws and regulations
- to be treated with dignity and addressed and respectful age-appropriate manner
- to be free from abuse neglect physical punishment and other miss treatment such as humiliation threats or exploitation

- to be the subject of an experiment or research only with my informed consent for the consent of the person legally authorized to act on my behalf
- to the extent that the facilities equipment and personnel are available to medical care and treatment in accordance with the highest standards accepted in medical practice
- to refuse treatment unless ordered by the court or authorized by my guardian except in case of an emergency
- consult a private practitioner at my expense.

Initial for client rights: _____

9. Consent for SMS

I authorize the use of text reminders. I understand fees may occur for the receipt of text depending on my phone plan.

Initial for SMS consent: _____

10. Consent for treatment

I understand that all OHBHS providers are independent contractors providing services under their own insurance and liability. Oak Hills Behavioral Health Solutions, LLC is not financially or otherwise liable for the practice of said independent providers.

I understand that OHBHS periodically serves as a clinical training site for mental health professionals with advanced degrees who have not yet obtained full licensure. These providers may be part of the care that I receive and my care is closely monitored /supervised by a fully licensed professional. I may decline services from or participation of these individuals by informing the front desk staff or the supervising provider of this choice. _____

11. Consent for follow up

I request the services of OHBHS providers and agreed to be contacted by a facility representative during or after my services to ascertain the results of my treatment and my satisfaction with the services that I received through OHBHS

Initial for consent for follow up: _____

I acknowledge by my signature that I have received or been offered a copy of Oak Hills Behavioral Health Solutions, LLC (OHBHS) Notice of Privacy Practices located in the OHBHS waiting area. I understand that if I have any questions regarding confidentiality, I may contact the clinic privacy officer at 660-372-1313.

Signature: _____ Date: _____

Printed name: _____

OHBHS Witness: _____ Date: _____