SHELTON
BEHAVIORAL HEALTH

Date _____

Patient Information

Name _____ SSN _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Birthdate _____ Marital Status ___ M ___S ___D ___W

Gender _____ Pronouns ___ he/him/his ___ she/her/hers ___ they/them/theirs

Employer/School _____

Referred By _____

Emergency Contact _____Relationship _____

Address _____ Phone Number _____

I understand that I am responsible for all financial charges.

Patient Signature _____

Responsible Party If Different From Above

Name _____ SSN _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Birthdate _____ Relationship to Patient _____

Employer _____

I understand that I am responsible for all financial charges.

Patient/Responsible Party Signature _____

Insurance Information

A copy of your insurance card will be made, so that insurance claims can be submitted.

The signature below enables the transmission of protected health information to your insurance company which they may require to process a claim.

Patient/Responsible Party Signature _____

SHELTON
BEHAVIORAL HEALTH

Notice of Patient Rights and Responsibilities

Shelton Behavioral Health recognizes that all patients have basic individual rights and responsibilities. To protect these rights, we have adopted specific guidelines to ensure the support and respect each patient's basic human dignity, as well as each patient's civil, constitutional and statutory rights. We respect each patient's right to participate in decisions about his or her care, treatment and services, and to give or withhold informed consent.

As a patient, you have the following rights and responsibilities. If you have any questions about these rights and responsibilities, please contact us at (859) 462-0066.

Patient Rights
As a patient, you have the right to:

- **Access to care:** You have the right to not be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, sexual orientation, gender identity, physical or mental handicap, or developmental disability. This includes the right to a current written, individualized service plan that addresses one's own mental and physical health, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.
- **Be treated with dignity and respect:** You have the right to be treated with respect for personal dignity, autonomy and privacy. This includes:
    - The right to be fully informed of all rights
    - The right to exercise any and all rights without reprisal, including continued uncompromised access to service
    - The right to be free from all forms of harassment, neglect, exploitation, and verbal, mental, physical and sexual abuse
    - The right to service in a humane setting which is the least restrictive feasible, as defined by the treatment
    - The right to freedom from unnecessary or excessive medication
    - The right to freedom from unnecessary restraint or seclusion
- **Participate in decisions about your care:** You have the right to be reasonably informed about and to participate in decisions made involving your healthcare, including the right of competent adults to refuse treatment. This includes:
    - The right to be informed of your condition, of proposed or current services, or therapies, and of the alternative

    - The right to consent or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal
    - The right to active, informed participation in the establishment, periodic review, and reassessment of the service plan
    - The right to participate in any appropriate and available organizational service, regardless of refusal of one or more other services, treatment or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the patient's participation in other services. This necessity shall be explained to the patient's current service plan
    - The right to be informed of and refuse any unusual or hazardous treatment procedure
    - The right to be advised of and to refuse observation by methods such as one-way mirrors, tape recorders, televisions, movies or photographs
    - The right to consult with independent treatment specialists or legal counsel at one's own expense
    - The right to be informed in advance of the reason (s) for discontinuation of service provision, and to be involved in planning for the consequences of that event
    - The right to receive an explanation of the reason for denial of service
    - The right to know the cost of services
- **Keep your medical records and identity private.** You can expect that any information, images, or recordings with information that could identify you will be kept private. This includes:
    - The right to confidentiality of communications and of all personal identifying information within the limitations and requirement for disclosure of various funding and/or certifying sources, state laws, or federal statutes, unless release of information is specifically authorized by the client or court appointed guardian of the person of an adult child
    - The right to have access to one's own psychiatric, medical, or other treatment records, unless access to particular identified items of information is specifically restricted to that individual patient for clear treatment reasons in the patient's treatment plan. "Clear treatment reasons" shall be understood to mean only severe emotional damage to the patient, such that the danger of self-injurious behavior is an imminent risk. The person restricting the information shall explain to the patient that factual information about the individual patient that necessitates the restriction. The restriction must be renewed annually to retain validity. Any person authorized by the patient has unrestricted access to all information. Patients shall be informed in writing agency policies and procedure to viewing or obtaining copies of personal records.
- **File a grievance:** You have the right to report concerns or complaints about your care and safety and receive help to resolve your concerns. This includes the right to have oral and written instructions for filing a grievance.

In order to protect each patient's rights, we have adopted the following procedures:

- Each patient shall receive this written Notice of Patient Rights during the intake procedure
- Patients will sign the Permission to Treat sheet indicating receipt of Notice of Patient Rights
- Copies of the Notice of Patient Rights are posted within the agency to ensure the patients as well as staff are well aware of the basic rights

If you feel that any of these rights have not been respected, then please follow our grievance procedure. We would like to help you get any complaint or concern resolved quickly and to your satisfaction. The grievance procedure will be posted in a visible place at the practice location.

Additionally, all Shelton Behavioral Health, LLC patients and/or guardians shall have the option to register a complaint with any or all, but not exclusively, the following:

- Ohio Department of Mental Health
- Ohio Legal Rights Service
- United States Department of Health and Human Services
- Appropriate professional licensing, regulatory associates, and/or other state departments. The names, addresses, and phone numbers of the aforementioned will be given to the griever. The relevant addresses and phone numbers about the grievance shall be included along with all relevant information about the grievance as requested.

Patient Responsibilities

As a patient you are expected to:

- Respect the dignity and rights of others, patients and staff alike, and to exercise care for the physical surroundings (practice property)
- Comply with all reasonable requests for information in the intake/admissions process
- Participate fully in the formulation of your treatment plan and to carry out the agreement to the fullest extent of your ability
- Respect the confidentiality of others, especially in the family, group, and educational sessions
- Give written permission for the release of necessary information to other institutions or professionals in the treatment program
- Contribute, according to the fee structure, to the cost of services

I have read and agree to all of the above information:

_____ _____

Patient or Guardian Signature Date

SHELTON
BEHAVIORAL HEALTH

Payment Policy

Thank you for choosing Shelton Behavioral Health to be a partner in your mental health treatment. We are committed to providing you with the highest quality professional services. We have developed this payment policy to clarify some of the common questions we receive regarding patient and insurance responsibility. Please review it, ask any questions you have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans. If we do not participate with your insurance, payment in full is expected at each visit. If we do participate with your insurance, but you do not have your most current insurance card, payment in full is expected at each visit until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Preauthorization:** If your insurance plan requires preauthorization before your first visit from you or your family doctor (PCP), this is your responsibility to secure as a member of your insurance plan. Such requirements will usually be stated on your health insurance identification card, with a special phone number listed to receive such authorization for mental health or substance abuse services.
3. **Co-payments:** All co-payments must be paid at the time of service. Unpaid copays must be paid in full prior to your next appointment or your appointment may be rescheduled. Your copay is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered insurance fraud. Please help us in upholding the law by paying your co-payment at each visit.
4. **Co-Insurance:** Your co-insurance balance will be billed to you once we receive the explanation of benefits (EOB) from your insurance company. This balance is due within eighteen (18) days of when we issue your statement. We are able to assist you with an estimate of the per visit co-insurance cost if needed.
5. **Deductibles:** If you have a high deductible plan we will contact your insurance company to confirm eligibility and obtain an estimate of your out-of-pocket cost for each visit. All insurance company contracts are different. If your insurance company allows for upfront collection of deductibles, you will be required to pay in full for your estimated out of

pocket cost at each visit. Any remaining balance is due with eighteen (18) days of when we issue your statement. In the event that a credit balance is due to you, the amount will be refunded within thirty (30) days of our receipt of payment from your insurance company. If your insurance company prohibits upfront collection of deductibles we recommend you consider making at least a partial payment at each visit. This will help you avoid a large payment suddenly becoming due once your visits process through your insurance. This full balance will be due within eighteen (18) days of when we issue your statement.

6. **Non-covered services:** Please be aware that some- and perhaps all of your condition is not covered under your policy- of the services you receive may be noncovered or not considered medically necessary by your insurer. Payment is required for those services in full at the time of the visit. Other fees that may not be covered by your insurance include letters, reports, completion of forms, etc. that are beyond standard coordination of care. Please ask your clinician if you have a question about non-covered services.
7. **Proof of Insurance:** All patients must provide photo identification and a current, valid insurance card before being seen by the clinician. If you fail to provide us with the correct insurance information at the time of your first visit, or at any point at which you obtain new insurance coverage, you may be responsible for the balance of your claim.
8. **Claims Submission:** We will submit your claims and assist you in any way reasonably possible to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with your insurance company's request as well as to comply within the given time specified by your insurance company. Please be aware that the balance of your claim is your responsibility. If your insurance company has not responded within forty-five (45) days, we will require you to contact them and at that point your claim balance will become your responsibility.
9. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will need to verify your benefits and verify that your clinician is on panel with your new insurance.
10. **Nonpayment:** If your account is over thirty (30) days past due we will be unable to schedule additional appointments except for a clinical emergency. An exception may be made if you contact us and make a payment plan arrangement with terms agreed upon by our office. If your account lapses to ninety (90) days past due, you will receive a letter stating that you have twenty (20) days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have thirty (30) days to find alternative care. During that 30-day period, our clinician will assist you with a referral to another agency.
11. **Missed appointments:** There is a $30 fee for missed appointments and late cancellations (within 48 hours of appointment). This fee will be your responsibility and cannot be billed to your insurance company. This fee must be paid in full prior to your next scheduled appointment or your appointment may be rescheduled. Please help us to serve

you better by keeping your regularly scheduled appointment. Patients who develop a pattern of frequent missed or cancelled appointments may be discharged from the practice.

12. **Financial Hardship:** If you experience temporary financial difficulties that affect timely payment of your account, please discuss this issue with your clinician at your earliest convenience, before any misunderstandings can develop. If your treatment has concluded and such questions or problems rise, contact your clinician.
13. **Uninsured Patients:** We may offer a reduced fee for uninsured patients who demonstrate financial hardship based on Federal Poverty Guidelines. If you feel you qualify, an application will be provided. You will be required to produce documentation of income. Eligibility for reduced fee must be updated every six months. For patients who do not qualify for reduced fee, a prompt pay discount is available.
14. **Non-Sufficient Funds:** There is a $25 fee for returned check.

If you have difficulty understanding your account of billing statements please contact our office and discuss this with your clinician.

Thank you for understanding. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

Permission to Treat and Acknowledgment of Policies

Please sign at the bottom to certify that you have read, understand and agree to each point. If the patient is a minor or has an appointed legal guardian, then the parent of the minor or the legal guardian, respectively, must sign:

- ***Permission to Treat/Informed Consent:*** I understand that my treating professional may use any and all customary procedures and treatments employed psychological outpatient or clinic facilities. I understand that there are risks involved in all treatment modalities and that my therapist can offer no guarantee regarding the outcome of the therapeutic measures in a specific case. I understand that my therapist will be using techniques and procedures consistent with prevailing standards and that I will be informed and will be asked for specific written consent for any high risk or "hazardous practice" procedures. I understand that I have the right to refuse any specific treatment procedures, but that if I refuse treatment that is in accord with professional standards, my therapist has the right to terminate treatment upon reasonable notice. My treatment professional will answer any and all questions I may have about my treatment plan or services.
- ***Notice of Patient Right and Responsibilities:*** I have received my copy of the Shelton Behavioral Health, LLC's Notice of Patient Rights and Responsibilities, and I agree to and understand its terms regarding my rights and responsibilities as a patient and the grievance procedure that I may utilize if I feel that my rights are being violated.
- ***Notice of Privacy Practices Policy:*** I have received a copy of the Notice of Privacy Practices followed by Shelton Behavioral Health, LLC, and I agree to and understand its terms regarding how my personal health information may be used. I understand that I can ask any questions that I may have about these policies at any time.
- ***Confidentiality:*** I understand that my discussions in treatment will remain confidential as afforded by ethical practice and by Ohio and Federal law, and my consent is required to release my records. I understand that there are legally mandated exceptions to confidentiality such as mandatory reporting of suspected abuse or neglect of a child or older adult, reporting of specific threats to harm another or oneself. A licensed therapist must also obey a court order to produce or discuss records.

- ***Authorization for Release of Information:*** I understand that treatment information such as diagnosis will be requested by my insurance company for claims processing and that information such as present complaints, previous treatment history, special risk factors, and treatment goals may be requested by my managed care organization if I have managed care rather than traditional health insurance. I have the right to refuse my insurance company and/or managed care organization to access my treatment information; however, if I exercise this right, I will be fully responsible for the cost of services I incur. Furthermore, I grant my permission for dates of service to be submitted electronically, if available, through my insurance carrier. From time to time my therapist may consult with colleagues regarding clinical or ethical issues of concern in my case in order to provide the highest quality care. I understand that my full identity will not be divulged in such a discussion, and that all professionals will respect my right to confidential communications.

I hereby authorize Shelton Behavioral Health to release any information in connection to my treatment to the following insurance company(ies) for the purpose of processing the insurance claim:

Insurance company(ies): _____

- ***Guarantee of Account:*** I understand that I am financially responsible for charges not covered by my insurance company. If any payment is due, it is expected at the time that services are rendered.
- ***Assignment of Insurance Benefits:*** I hereby authorize payment of the benefits otherwise payable to me by the designated insurance company(ies) directly to Shelton Behavioral Health, the amount not to exceed regular charges.

Your signature below indicates that you have read and understand this form and agree to its terms. Additionally, your signature indicates that you give your treating professional(s) permission to treat you and that you consent to such treatment.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name of Patient or Representative

_____

Representative's Relationship with Patient (If Applicable)

SHELTON
BEHAVIORAL HEALTH

Patient Name: _____

DOB: _____

____ I give my permission for Shelton Behavioral Health to call, text or email, and if necessary leave a reminder message for an upcoming appointment

Phone number: _____

Email: _____

____ I do not want reminder calls/texts/emails

Reminder calls/texts/emails are a courtesy only. Any missed appointments remain the patient's responsibility.

_____ _____

Patient/Legal Guardian Signature Date

SHELTON
BEHAVIORAL HEALTH

TELEPSYCHOLOGY INFORMED CONSENT

In the event that technology (including but not limited to the use of phone, text, email and credit card processing) is used in the course of the service provided by this office, I understand and agree that:

1. There are benefits and limitations to the use of technology. I will need access to, and familiarity with, the appropriate technology to participate in the service provided. While greater convenience in service delivery can be achieved through the use of technology, there are risks to its use. These include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

2. Text messaging will be reserved for the transmission/exchange of non-clinical information only, such as appointment scheduling or administrative concerns.

3. It is my responsibility to maintain privacy on my end of communication. Insurance companies, those authorized by me, and those permitted by law may also have access to records or communication.

4. Dr. Shelton currently uses Square and/or SimplePractice to process credit card payments. Square and SimplePractice's user agreement indicates that they may store and use some identifying information (PHI) such as my name and email address, as do many credit card processing services.

5. If I take part in regularly scheduled telebehavioral health sessions, and a need for direct, face to face services arises (either because of a disruption in technology, clinical emergency, or any other reason) it is my responsibility to contact service providers in my area such as:

- Call 911
- Go to nearest emergency room
    - Mercy Health- St. Joseph Hospital Warren
        - 667 Eastland Avenue SE Warren, Ohio 44484
        - (330) 841-4000
    - Trumbull Memorial Hospital
        - 1350 E Market Street Warren, Ohio 44484
        - (330) 841-9011
    - Mercy Health- St. Elizabeth Youngstown Hospital
        - 1044 Belmont Avenue Youngstown, Ohio 44501
        - (330) 746-7211

or to contact Dr. Shelton at (859) 462- 0066 for an office appointment. I understand that an immediate opening may not be available.

6. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This document does not replace other agreements, contracts, or documentation of informed consent.

_____

Printed Patient Name

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Signature of Minor (if applicable) Date

Authorization for Release of Health Information Pursuant to HIPAA
Shelton Behavioral Health

__ I prefer NOT to allow exchange of information between Shelton Behavioral Health and my primary care provider
__ I do not have a primary care provider

PATIENT _____ DOB_____ LAST FOUR SSN#_____

I THE UNDERSIGNED AUTHORIZE THE EXCHANGE OF INFORMATION BETWEEN:

Shelton Behavioral Health, LLC
_____

←AND→

Primary Care Provider:

Address:
_____

City/State:
_____

Phone/Fax:
_____

INFORMATION TO BE RELEASED BY SHELTON BEHAVIORAL HEALTH INCLUDES THE FOLLOWING:

Diagnosis
Recommendations
Discharge Summary
Treatment Plan
Summary of Treatment

REQUESTED INFORMATION FROM PRIMARY CARE PROVIDER INCLUDES THE FOLLOWING:

History and Physical
Treatment Plan
Treatment/Office Visit Notes
Medical Evaluation
Current Medications/Medication History

THE EXCHANGE OF INFORMATION IS FOR THE SPECIFIC PURPOSE OF:
Ensuring proper coordination of care with patient's primary care provider.

I UNDERSTAND:

1. This authorization will expire on _____ date, event, or condition not to exceed 1 year). If not dated, then this authorization will automatically expire one year from the date of signing.
2. I may revoke this authorization at any time by signing the "Revocation of Authorization" portion of this form, below, and providing a copy to the releasing party or by providing any other form of written revocation to the releasing party. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization.
3. Signing this authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this authorization.
4. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA upon its release to the recipient.

I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of records designation above, which may include treatment for mental illness (ORC 5122.31), alcohol/drug abuse (42 CRF Part 2), and/or Human Immune Deficiency Virus (HIV) Acquired Immune Deficiency Syndrome (AIDS) test results or diagnoses (ORC 3701.24.3).

_____ _____
_____

Signature of Patient/Parent/Guardian
Relationship to Patient

Date

REVOCATION OF AUTHORIZATION:
I hereby withdraw my consent for any further release of information as of the date indicated below:

_____ _____

_____

Signature of Patient/Parent/Guardian Date
Relationship to Patient

TO THE RECIPIENT: This information has been disclosed to you from confidential records protected by Federal Law. You are prohibited from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. If you have received this information in error please notify Shelton Behavioral Health, LLC immediately.