Outpatient Program Admission Consents

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Are you completing this form for someone other than yourself? ☐ YES ☐ NO

Patient Name:
Birth Date:
SSN:
Your Name (If completing on behalf of someone else):
Relationship to Patient:

A. Basic Informed Consent

I understand that treatment at Youth Home may involve discussing relationships or emotional issues that may sometimes be distressing. However, I also understand that this process is intended to help me personally and with relationships.

I understand ☐ INITIALS

I have been informed of my Rights and Responsibilities as a Youth Home patient and I understand them, along with the reasons that I could be denied services, or referred to another treatment facility. I understand that confidentiality exists unless there is a threat of harm to myself or others or when there is suspected or reported abuse to minors.

I agree ☐ INITIALS

I have received a copy of "A Message to Patients" and I have been given the name, address, and phone number of my therapist and the Outpatient Clinic.

I agree ☐ INITIALS

My therapist has satisfactorily answered all of my questions about therapy and if I have further questions, my therapist will either answer them or help me find answers. I understand that I may leave therapy at any time, although I have been informed that it is best if I discuss this with my therapist.

I agree ☐ INITIALS

I have received a copy of "A Message to Patients" and I have been given the name, address, and phone number of my therapist and the Outpatient Clinic.

I agree ☐ INITIALS

B. Mandated Reporting

Federal law regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. & 290ff-3 for federal laws and CR CFR Part 2 for federal regulations.) Youth Home staff are all mandated reporters.

I understand ☐ INITIALS

C. Confidentiality of Alcohol and Drug Abuse Client Records

The confidentiality of alcohol and drug abuse patient records maintained by Youth Home is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser. In addition, Youth Home, Inc. will not disclose information regarding whether or not an individual is receiving services as a client of Youth Home/BHSA or release any potentially identifying information of treatment for a client, unless:

The patient consents in writing; OR
The disclosure is allowed by a court order; OR
The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; OR
The Patient commits or threatens to commit a crime either at the agency or against any person who works for the agency
Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.
Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.
Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. ☐ INITIALS

D. Consent for Treatment

Medicaid (Medical Assistance) is designed to assist eligible Medicaid beneficiaries in obtaining medical care. Outpatient Behavioral Health Services (OBHS) are covered by Medicaid when provided to eligible Medicaid beneficiaries by enrolled providers. Services provided through Behavioral Health Services of Arkansas, Day Treatment, and Community Residential Treatment (Cartwright House) are OBHS services.

OBHS are limited to certified providers who offer core mental health services for the treatment and prevention of mental disorders. The provider must be certified as an OBHS provider by the Division of Behavioral Health Services.

OBHS, based on a plan of care, include a broad range of services to Medicaideligible beneficiaries. Beneficiaries shall be served with an array of treatment services outlined on their individualized master

treatment plans in an amount and duration designed to meet their medical needs. All OBHS must be medically necessary.

For beneficiaries eligible for Rehabilitative Level Services, the physician will see and evaluate the individual within 45 days of the eligibility determination. This evaluation is not required if the beneficiary discontinues services prior to calendar day 45. The beneficiary must be re-evaluated directly by a physician within one year after the date of the examination and at least every year thereafter.

I understand that third party payers such as Medicaid and insurance may deny payment based on the third party payer's policies or rules. In the event that should occur, I understand that I will become a self-pay client and may be eligible for Youth Home's sliding fee scale.

The OBHS rules may be accessed at www.medicaid.ar.us.gov. A copy of the rules will be provided upon request.

Services may be discontinued at any time by the client or client's parent /guardian if under 18.

I give Youth Home, Inc. permission for treatment of myself or my minor child, whose name will appear at the top of this document. I understand that this may include individual, family, or group treatment, along with medication assessment or testing. This treatment may also include referrals to other appropriate state and county or professional agencies for further counseling.

I have read and understand the Consent for Treatment.

I understand ☐ INITIALS

E. Information Obtained

(To be completed by Patient/Parent/Guardian)

I have received the name and phone number of Disability Rights Arkansas as well as the phone number and email address for The Joint Commission.	YES
I have had the Patient Rights Policy of Youth Home, Inc. explained to me. I understand these rights and responsibilities.	YES
I have also had the Patient Grievance Procedure explained to me. I understand this process.	YES
I acknowledge that I have received a copy of Youth Home, Inc.'s Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice by accessing Youth Home, Inc.'s website at www.youthhome.org, or by requesting one at Youth Home.	YES

☐ INITIALS

F. Outpatient Program Admission Consents Patient Financial Responsibility

As a patient, it is in your best interest to know if your insurance plan is contracted with Youth Home Family Therapy Services, and to understand your plan benefits and your responsibilities for any deductibles, co-insurance, or co-payment amounts, depending on the contracted status of your insurance company.

It is also important to understand your insurance plan's current benefit and coverage rules. Policies and coverage determinations may vary from year to year.

To minimize unexpected costs to you or your family, please make sure that both your clinician and clinic are listed as contracted providers by your insurance company. While we work hard to enroll our clinical staff in insurance panels, it is possible that only the clinician or only the clinic is contracted with your insurance plan. If not listed, contact your plan's customer service department or Youth Home at 501-954-7470 to verify.

If the clinic and/or the clinicians are not listed as contracted providers and/or are not in your insurance company's network, we are still happy to accept your
insurance and provide you with services. If your policy has out-of-network
benefits, your insurance plan may still cover the services provided to you at Youth Home, but you may be responsible to pay a higher amount out-of-pocket than if you received services from an in-network provider. Your insurance company's customer service representative can help verify your benefits and out-of-pocket cost. Should you require additional assistance regarding your out-of-pocket cost, we can provide you with financial assistance options.

Also, not all services are covered in all insurance contracts. If your insurance\ plan benefits do not cover a service or procedure, you can be held personally responsible for payment of these charges. To find out what your insurance plan benefit covers and what your financial obligation may be, call the customer service or member services department of your insurance company (the phone numbers are on your insurance card). Your employer's human resources department may also be a source of information and assistance.

Patients with insurance questions or concerns may also contact Pratima Wilkins, Billing & Financial Manager at 501-954-7470.

I have read and understand the Patient Financial Responsibility.

I understand ☐ INITIALS

G. Outpatient Services Fee Contract

I understand that all fees are due on the date that services are rendered and must be paid. I agree to assign Youth Home all insurance benefits related to services from Youth Home, Inc. I understand that third party payers such as Medicaid or insurance may deny payment based on the third party payer's policies or rules. Services may be discontinued at any time by the client or client's parent/guardian if under 18. By signing , I acknowledge I have had Youth Home's Fee Contract explained to me, and I understand this process.

I understand ☐ INITIALS

H. Consent to E-Mail Communications

I affirm that I understand the following:

1. E-mail communications are for convenience and are not appropriate for emergency or urgent care situations.	I understand
2. I will not use e-mail to obtain medical advice. In particular, medical complaints, diagnoses, test results, etc. will not be discussed.	I understand
3. Youth Home staff will monitor their e-mail regularly, and I agree to monitor the above e-mail boxes regularly and respond as needed.	I understand
4. E-mail communication based upon this authorization may or may not become part of the patient's records at Youth Home, as determined by Youth Home.	I understand

5. E-mail is not a totally secure and confidential means of communication.	I understand
6. It is my responsibility to safeguard the private health information transmitted via e-mail once it has been received from Youth Home.	I understand
7. Youth Home, Inc. is not responsible for breach of private health information that has been transmitted via e-mail at my request. (A separate Request for Access form will be completed for records requested via e-mail.)	I understand
8. E-mail information which I provide may be used for routine care, payment, and other business operations of Youth Home and may be shared with medical consultants as deemed necessary by Youth Home.	I understand
9. The subject line of each e-mail I send will indicate the nature of the e-mail.	I understand
10. I will contact Youth Home by phone if I am not getting a response from Youth Home by e-mail after an appropriate time, and I agree that the length of that time period is my judgment to make.	I understand

Your Email: ☐ INITIALS

I. Current Medications

List any medications you are currently taking

	Medication	Dosage	Reason	Doctor
Medication 1				
Medication 2				
Medication 3				
Medication 4				
Medication 5				

J. Controlled Substance Contract

1. All controlled substances have a potential for dependency and abuse.
2. Narcotics (pain pills) are not psychiatric medicines and we do not prescribe them.
3. All benzodiazepines or stimulants must come from the physicians whose signature appears below, or during his/her absence, by covering physicians unless specific authorization is obtained for an exception.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with the dispensing pharmacists or other professionals who provide your health care for the purpose of maintained accountability
5. You may not share, sell, or otherwise permit others including spouse or family members to have access to these medications.
6. You agree to not consume excessive amounts of alcohol in conjunction with prescribed controlled substances. Additionally you agree to not purchase, obtain or use any illegal drugs.
7. Medications will not be replaced if they are lost, stolen, get wet, destroyed, left on an airplane, etc.
8. Early refills will not be given. Renewals are based on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

9. In the event you are arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given.
10. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by BHSA psychiatrists.
11. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understood, and accept all its terms.
12. You agree to allow us access to your past prescriptions history.

I have read and understand the BHSA Controlled Substance Contract.

I understand ☐ INITIALS

K. Insurance Verification & Billing

I hereby authorize BEHAVIORAL HEALTH SERVICES OF ARKANSAS, a division of Youth Home, Inc., to contact my insurance carrier (shown below) in order to determine eligibility for mental health services. I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered by the therapist, physician and/or facility, I will within five days of receipt of this check make payment in the amount of said check to the facility. The following also applies to the use of my insurance to cover the cost of services rendered:

Authorization to Release Medical Information for Billing

I hereby authorize the release of any information regarding services by the Physician/Facility to process insurance claims and allow a photocopy of my signature to file insurance claims.

Assignment of Insurance Benefit

I hereby authorize irrevocably assignment of payment for my benefits due me for the services rendered by the physician and the facility made directly to the physician and/or the facility.

Financial Responsibility

I understand that if I am utilizing an "out of network" provider for the services rendered by the therapist, physician and/or facility, then I understand, regardless of my insurance benefits, that I alone am fully financially responsible for the fees for the services rendered. I agree to collect charges which will be added to my past due accounts. ☐ INITIALS

Primary Insurance Info

	Please complete as much as possible
Primary Insurance Provider:	
Subscriber:	
Policy ID#	
Group #	
Amount of Deductible:	
How much is met?	

Secondary Insurance Info

	Please complete as much as possible
Secondary Insurance Provider:	
Subscriber:	
Policy ID#	
Group #	
Amount of Deductible:	
How much is met?	

L. Informed Consent for Technology Assisted Counseling/Online Counseling

I. PROCESS - A: Possible misunderstandings: The client should be aware that misunderstandings are possible with telephone, text-based modalities such as email, and real--time internet chat, since nonverbal cues are relatively lacking. Even with video chat software, misunderstandings may occur, since bandwidth is always limited and images lack detail. Counselors are observers of human behavior and gather much information from body language, vocal inflection, eye contact, and other non-verbal cues. If you have never engaged in online counseling before, have patience with the process and clarify information if you think your counselor has not understood you well. Be patient if your counselor asks periodically for clarification as well.

I Understand ☐ INITIALS

II. POTENTIAL BENEFITS: The potential benefits of receiving mental health services online include both the circumstances in which the counselor considers online mental health services appropriate and the possible advantages of providing those services online. For example, the potential benefits of email may include: (1) being able to send and receive messages at any time of day or night; (2) never having to leave messages with intermediaries; (3) avoiding not only intermediaries, but also voice mail and "telephone tag"; (4) being able to take as long as one wants to compose, and having the opportunity to reflect upon, one's messages; (5) automatically having a record of communications to refer to later; and (6) feeling less inhibited than in person. Text-based chat has many of the same advantages of convenience, feeling reduced scrutiny from the counselor, having time to compose a response and being able to refer back to the chat log for reference.Video chat is also convenient, allowing clients to potentially be counseled from anywhere once they can gain an internet signal and operate the necessary hardware.

I Understand ☐ INITIALS

III. POTENTIAL RISKS: There are various risks related to electronic provision of counseling services related to the technology used,the distance between counselor and client, and issues related to timeliness.For example, the potential risks of email based counseling may include (1) messages not being received and (2) confidentiality being breached through unencrypted email, lack of password protection or leaving information on a public access computer in a library or internet cafe. Messages could fail to be received if they are sent to the wrong address (which might also be a breach of confidentiality) or if they just are not noticed by the counselor. Confidentiality could be breached in transit by hackers or Internet service providers or at either end by others with access to the client's account or computer. People accessing the internet from public locations such as a library, computer lab or cafe should consider the visibility of their screen to people around them.Position yourself to avoid peeping by those around you. Using cell phones can be risky in that signals are scrambled but rarely encrypted.

I Understand ☐ INITIALS

IV. SAFEGUARDS: Your counselor has selected an online account with Doxy.me. We will use your email address and you will be sent an invite to join us for the sessions. The client is responsible for creating and using additional safeguards when the computer used to access services may be accessed by others, such as creating passwords to use the computer, keeping heir email and chat IDs and Passwords secret, and maintaining security of their wireless internet access points (where applicable). Please discuss any such concerns with your counselor early in your first session so as to develop strategies to limit risk.

I Understand ☐ INITIALS

V. ALTERNATIVES: Online counseling may not be appropriate for many types of clients including those who have numerous concerns over the risks of internet counseling, clients with active suicidal/homicidal thoughts, and clients who are experiencing active manic/psychotic symptoms. An alternative to receiving mental health services online would be receiving mental health services in person. The online counselor can and will assist clients who would like to explore face-to-face options.

I Understand ☐ INITIALS

VI. CONFIDENTIALITY OF THE CLIENT: The counselor only treats clients who are legally in a position to consent for themselves to receive mental health services. Clients who are not in such a position include children under the age of consent (18 in most cases) or clients who have a legally appointed guardian.

If a counselor believes that someone is seriously considering and likely to attempt suicide	I Understand
If a counselor believes that someone intends to assault another person	I Understand
If a counselor believes someone is engaging or intends to engage in behavior which will expose another person to a potentially life-threatening communicable disease	I Understand
If a counselor suspects abuse, neglect, or exploitation of a minor or incapacitated adult	I Understand
If a counselor believes that someone's mental condition leaves the person gravely disabled	I Understand

☐ INITIALS

VII. RECORDS:The counselor will maintain records of online counseling services. These records can include reference notes, copies of transcripts of chat and internet communication and session summaries. These records are confidential and will be maintained for seven years as required by applicable legal and ethical standards according to the American Counseling Association. The client will be asked in advance for permission before any audio or video recording will occur on the counselor's end.

I Understand ☐ INITIALS

VIII. PROCEDURES: The counselor might not immediately receive an online communication or might experience a local backup. If the client is in a state of crisis or emergency, the counselor recommends contacting a crisis line or an agency local to the client. Clients may utilize the following crisis hotlines:.

1-800-SUICIDE	I Understand
1-800-273-TALK	I Understand
For the Deaf: 1-800-799-4TTY	I Understand
Work with your counselor to identify local resources if you have concerns about the timeliness of responses	I Understand

☐ INITIALS

IIX. DISCONNECTION OF SERVICES: If there is ever a disruption of services on the internet, then the client will need to call 501-954-7470.

I Understand ☐ INITIALS

M. Signature

Please sign:	**Date:**