Version 1.0

LIVE OAK
BEHAVIORAL HEALTH

Consent and Acknowledgement

Explanation of Consent: This consent form is for you to participate in an assessment and/or treatment at Live Oak Behavioral Health, P.A. Assessment and treatment may include, but are not limited to: individual psychotherapy/ intervention, group therapy, and psychological/neuropsychological testing. It is important that you understand that no one, including the professional providers at Live Oak Behavioral Health, P.A. can guarantee any particular outcome of treatment or that the treatment will be successful.

My Responsibility: I understand that I am an active participant in the evaluation and treatment process and that I share responsibility for my treatment. I understand that it is up to me to inform my clinician of any information that may be important to the symptoms or conditions being addressed in assessment and treatment. I will do my best to follow recommendations and therapeutic advice.

Emergency Procedures: Live Oak Behavioral Health, P.A. is NOT able to provide 24-hour emergency or crisis management services to its clients. If you have an emergency or are in a crisis when the Live Oak Behavioral Health, P.A. clinic is not open, call 911 or visit the nearest emergency room. Additionally, mental health crisis intervention is available at Aspire Health Partners (call 407-875-3700 in Orange County or 407-323-2036 in Seminole County).

_____Client Initials

By signing below:

I, _____, for _____
(Print your name as a consenting adult or Guardian) (Print name of Client, whether yourself or another)

of my own wishes, agree to receive care and treatment and/or participate in an assessment at the Live Oak Behavioral Health, P.A. clinic. If I am agreeing to assessment and/or treatment services for another individual (e.g. a person that I have legal guardianship for), by signing this form, I verify that I am legally responsible for this person and have the legal authority to consent to treatment for him or her. I understand that the practice of Clinical Psychology is not an exact science, and no one can guarantee what the result of evaluation and treatment services will be. I agree that this form has been fully explained to me and that I understand all of the information on this form. I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____
Client or Legal Representative Signature Date

_____
Witness Signature Date

_____ My initials here mean that I have received a copy of this consent for my records.

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BEHAVIORAL HEALTH

Live Oak Behavioral Health, P.A.
341 N. Maitland Ave, Suite 120
Maitland, FL 32751
407-756-2084

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

This notice describes how psychological and medical information about you may be used and disclosed and how you can gain access to this information. It contains summary information about the Health Insurance Portability and Privacy Accountability Act (HIPPAA), a Federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and healthcare operations. Please review it carefully.

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

Live Oak Behavioral Health, P.A. (hereafter referred to as 'the Clinic') may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you such as your name, date of birth, phone number, or address
- *"Treatment, Payment, and Health Care Operations"*
  - *Treatment* is when we provide, coordinate, or manage your therapy or assessment and other related services. In addition to direct services, this might include such things as consultation with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when we obtain reimbursement for your healthcare, either directly from you or from a third party.
  - *Health Care Operations* are activities that relate to the performance and operation of the Clinic. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and care coordination.
- *"Use"* applies only to activities within the Clinic, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of the Clinic, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

The Clinic may use or disclose PHI for purposes outside of treatment, payment, and health care operations as provided below or 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 the Clinic is asked for information for purposes outside of treatment, payment and health care operations, an authorization from you will be obtained before releasing this information.

You may cancel all such authorizations at any time, provided each cancellation is in writing. Cancellation of an authorization does not apply to the information that as already been released.

III. Used and Disclosures with Neither Consent nor Authorization

PHI may be disclosed without your consent or authorization in the following circumstances:

- *Child Abuse*: If there is cause to believe that a child has been, or may be, abused, neglected, sexually abused, or exploited we are legally mandated to make a report of such to the Abuse Hotline operated by the Florida Department of Children and Families.
- *Abuse of a Vulnerable Adult*: If there is cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we are legally mandated to make a report of such to the Abuse Hotline operated by the Florida Department of Children and Families.
- *Health Oversight*: If a complaint is filed against the Clinic or any of its clinicians or supervisors with the State Department of Health or Board of Psychology, the Board has the authority to subpoena confidential mental health information relevant to that complain and the Clinic is required to respond to the subpoena.
- *Judicial or Administrative Proceedings*: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged (protected) under state law, and will not be released without written authorization from you or your personal or legally appointed representative, or a court order. The privilege (protection) 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.
- *Serious Threat to Health or Safety*: If it is determined that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, relevant confidential mental health information may be released to medical or law enforcement personnel.
- *Worker's Compensation*: If you file a worker's compensation claim, records relating to your diagnosis and treatment may be disclosed to your employer, employer's insurance carrier, and/or their attorneys.

IV. Patient's Rights and Provider's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, the Clinic is 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 being seen at the Clinic. Upon your request, and communications maybe to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. There may be a small charge for copying a record. Your access to PHI may be denied under certain circumstances, but in some cases you may have this decision reviewed. On your request, our staff will discuss with you the details of the request and review 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. Your request may be denied, but this is also subject to review. On your request, our staff will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive and accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, our staff 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 this notice.

Provider's Duties:

- The Clinic is required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI, and to notify you in the event your PHI is breached.
- The Clinic reserves the right to change the privacy policies and practices described in this notice. However, unless you are provided with the updated notice, we are required to abide by the notice currently in effect.

V. Complaints

If you are concerned that anyone at the Clinic has violated your privacy rights, or you disagree with a decision regarding access to your records, you may contact the Business Manager (Kirsten Paulson, kirsten.paulson@liveoakbehavioralhealth.com) or the Florida Department of Health Division of Medical Quality Assurance (850-245-4339 or www.floridahealth.gov/licensing-and-regulation/enforcement).

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person or agency listed above can provide you with the appropriate address upon request. You will not be retaliated against for filing a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on January 5, 2018

Live Oak Behavioral Health, P.A. reserves the right to change the terms of this notice and to make the new notice provisions effective for al PHI that is maintained. You will be provided with a revised notice in person or by mail (or email if appropriate) prior to the revisions taking effect.

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Acknowledgement of HIPAA Statement

I acknowledge that I have received a copy of Live Oak Behavioral Health's HIPAA Notice of Privacy Practices.

_____
Patient Name

_____ _____
Patient Signature Date

_____ _____
Witness Date

Version 1

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Patient Information

Name_____
First Middle Last

Phone Numbers:
Mobile:_____
Home:_____
Work:_____

E-Mail Address: _____

Home Address:_____
City:_____
ZIP:_____

Date of Birth_____ Social Security Number_____
Sex: ___ Male ___ Female Race:_____
Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed
Religion: _____

Occupation: _____ Employer: _____

Emergency Contact

Name:_____ Relationship:_____
Phone Numbers:
Mobile:_____
Home:_____
Work:_____

How did you learn about Live Oak Behavioral Health, P.A.?

_____

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Communication Authorization

Your signature will serve as authorization for all of the following:

Live Oak Behavioral Health, P.A. may contact me at my primary phone number or other alternate phone number I have provided.

___Yes ___No

Live Oak Behavioral Health, P.A. may leave a voicemail at my primary phone number or other alternate phone number I have provided.

___Yes ___No

Live Oak Behavioral Health, P.A. may contact me via text at my primary phone number or other alternate phone number I have provided to remind me of future appointments or to alert me of documents that need my attention prior to a scheduled appointment.

___Yes ___No

Live Oak Behavioral Health, P.A. may e-mail my personal e-mail address, or any other alternate e-mail I have provided to me items such as appointment reminders and patient statements.

___ Yes ___ No

_____
Signature

_____
Print Name

_____
Date

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Billing Agreement

Client Name _____

Client Number_____

The undersigned party hereby acknowledges and understands that:

1. The client shall be charged $_____ per 50-minute session of professional services rendered to the client by behavioral health professionals employed by Live Oak Behavioral Health. Every 15-minute increment added to the regular 50-minute session will be billed at the rate of $30.00 per 15-minutes.
2. To protect our clients' confidentiality, and to reduce administrative costs, we ask that clients pay out-of-pocket for behavioral health services. We are happy to provide a simple billing statement that may submitted for "out of network" insurance reimbursement and/or for tax purposes.
3. Credit card information will be kept with your confidential file, and charges will be processed weekly. Clients will receive a detailed statement at the end of each month, which will include the month's sessions and payments recorded. Failure to keep current on your bill or to make a written alternative plan with Live Oak Behavioral Health may result in the termination of therapy.
4. Appointment Cancellations: If you need to cancel or reschedule your session, please do so at least 24 hours in advance. Live Oak Behavioral Health reserves the right to charge a $40 fee for sessions that are either missed or cancelled less than 24 hours in advance. Cancellation requests must be communicated by phone.
5. If the client has not made payments, or the parties have not executed other written arrangements, the client hereby agrees that all costs, including legal expenses, necessary for the enforcement of this agreement shall be recoverable by Live Oak Behavioral Health.
6. Returned checks will incur a $40.00 service fee, to be paid at the time of the next appointment.

I agree that, in signing this billing agreement, I have read and fully understand the terms contained herein. I am responsible for a fee of $_____ per session. Fees are due at the time of the scheduled session, and may be billed to the provided credit card number at any time within 7 days of the completed or missed session. Professional fees may be renegotiated in a new fee agreement from time to time. In the event of nonpayment, I understand that my account may be turned over to a collections agency.

Credit Card Information

Card Type _____ Number _____

Expiration Date_____ Card Security Code _____

_____
Client Name

_____ _____
Client Signature Date

_____ _____
Witness Date