Lincoln Behavioral Health Clinic

Authorization to Treat

AUTHORIZATION TO TREAT:
I authorize and direct my psychologist/therapist and his/her designee to provide psychological services for me, as they deem necessary and appropriate. I understand that I have the right to receive information, to ask questions and to receive answers to my questions about my treatment plan. I also have the right to refuse treatment and to seek a second opinion.

ASSIGNMENT OF BENEFITS:
I hereby assign all medical insurance benefits, including Medicare/Medicaid, private insurance and any other health plans to Lincoln Behavioral Health Clinic. I understand that I am financially responsible for all allowed charges, yearly deductibles, or co-insurance amounts, which are not paid by my insurance company.

RELEASE OF INFORMATION TO INSURANCE COMPANY:
I authorize Lincoln Behavioral Health Clinic to release to the Medicare and/or Medicaid carrier and/or my insurance carrier, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim be made directly to Lincoln Behavioral Health Clinic.

NEBRASKA STATE LAW REGARDING MINORS:
Nebraska state law defines a minor as anyone 19 years of age and younger. These patients are required by law to have a legal guardian present or, if this is not possible, you must make prior arrangements with our office. If prior arrangements are not made, it could result in the appointment needing to be rescheduled.

I also understand that I will be responsible for all charges if the insurance information I provided is not correct or if I do not notify the office of any insurance change.

Signature: _____

Lincoln Behavioral Health Clinic

Notice of Privacy Practices ("NPP")
– Short Version –
PLEASE REVIEW CAREFULLY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your personal health information. We are also required by law to do this. This document is a shorter version of the full, legally required Notice of Privacy Practices ("NPP") a laminated copy of which you received along with this; please refer to it for more information. If you have further questions or concerns about possible situations in addition to those discussed below, please contact the front office at 402.489.9959.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services or for some other business activities which are called **health care operations.** After you have read this **NPP** we will ask you to sign a **Consent to Treatment** form. We cannot treat you without your consent to this NPP.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization to allow this. We will keep your health information private, but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share the information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

Additional situations like these, which are less common. They are described in the long version of the NPP.

Your rights regarding your health information:

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or it is an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records, but we may charge you. Contact our Privacy Officer to arrange how to see your records. (See below.)

Lincoln Behavioral Health Clinic

Notice of Privacy Practices ("NPP") – Short Version (cont.)

4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing documenting the reason for changes and send it to our Privacy Officer.

5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and you can request a copy of the NPP from the front office or the Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. All complaints must be in writing and can be filed with our Privacy Officer and with the Secretary of the Department of Health and Human Services. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our office at (402) 489-9959 or by email at frontdesk@lbhc.biz.

The effective date of this notice is September 1, 2020.

Signature: _____ **Date:** _____

Lincoln Behavioral Health Clinic

Consent to Treatment and Confidentiality Statement

This form is an agreement between you,_____(your name/minor's name), and Lincoln Behavioral Health Clinic ("LBHC" and "we"). All statement below stating: "I", "me", "my", "myself", "you", and "your" refer to whomever is listed above.

In compliance with the ethical and legal guidelines set forth by the American Psychological Association and the American Counseling Association, my psychologist/counselor has explained that my participation in therapy is completely voluntary and confidential. In signing this document, I understand that I may refuse and/or terminate services for myself and/or my minor child at any point during the counseling process, without adverse repercussions between LBHC and myself.

We use PHI information to: Determine the best course of treatment for you, to provide treatment to you, to arrange payment for your treatment, or for other business or government functions. I understand that LBHC and my provider will maintain PHI records relevant to therapy, as well as information obtained through consultation with other professionals. I understand that these records are restricted to the internal use of LBHC and confidentiality will be strictly maintained at all times.

I understand that LBHC has employed administrative assistants who manage the billing, scheduling, filing, and other miscellaneous office duties and that these individuals are also required to uphold the state and federal guidelines with regard to maintaining confidentiality. LBHC will only release information regarding my care upon receipt of my written consent and only to those specified by myself, except in unusual circumstances. In circumstances where there is risk of danger and/or impending harm to myself or others, child abuse, and/or certain legal situations (ie, court subpoena), LBHC is mandated by law to disclose such information for my protection and/or that of others or for legal reasons. In such situations, my therapist will make reasonable attempts to discuss the situation with me and enlist my participation in resolving the matter, if possible. If I have any questions, I understand that I can discuss them freely with LBHC and my provider.

By signing this form, you are agreeing to let us use your information here and to send it to others. The Notice of Privacy Practices (also "NPP") explains in more detail your rights and how we can use/share your information. You are welcome to request copy of NPP for your record. If you do not sign this consent form agreeing to our Notice of Privacy Practices, we cannot treat you.

You have the right to ask us not to use or share some of your information for treatment, payment or administrative purposes. This request must be made in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. You have the right to revoke consent in writing. We will comply with your wishes about using or sharing your information from the date of written revocation.

Signature: _____ **Date:** _____

Lincoln Behavioral Health Clinic

Insurance Policies

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of each plan. Each one has different stipulations regarding how often service may be rendered. Even within the same insurance company, plans may differ depending upon what type of contract your employer has negotiated.

Providing quality care for our patients is our primary concern. We are happy to provide that care within your insurance contract guidelines if you let us know exactly what those guidelines are. We will check your eligibility and benefits, but it is your responsibility to also be aware of your coverage.

All copays are due at the time of service as indicated by your insurance benefits. Insurance policies vary and the possibility remains that your insurance company may apply your charges to a deductible or require additional co-insurance to be paid by you. We have no control over how your claim is processed by your insurance company and any issues related to processing of claims must be addressed by your insurance carrier.

I have read and understand the office insurance policy stated above and agree to accept responsibility as described.

Print Name: _____

Signature: _____ **Date:** _____

Lincoln Behavioral Health Clinic

Bill of Rights and Responsibilities

CLIENT'S RIGHTS:

As a person receiving behavioral health services at LBHC, you have the right to:

- Be treated with dignity and respect, regardless of race, age, sex, religion, national origin, sexual orientation, disability, or marital status.
- Reasonable accommodation of a physical disability that impacts your ability to access treatment services, within ethical guidelines.
- Be informed of your treatment plan, goals and diagnosis and related information.
- Participate fully in the development of the treatment program.
- Ask questions and receive answers about services.
- Expect that your treatment services will remain confidential within the guidelines of federal and state laws and professional ethics.
- Request changes in treatment or services.
- Terminate treatment or service unless ordered by a Court to participate.
- Participate fully in decisions regarding your discharge plan from services.
- Choose to include your family or others in your treatment.
- Make complaints, have them heard, and receive a prompt response.
- Review your record, with the exception that limited portions of your records can be withheld from you if your treatment provider deems that it would be harmful to you and your treatment.
- Provide written consent for the disclosure of personal health information, with exceptions, including information related to risks to your health and safety or someone else's health and safety, your insurance carrier, or your legal guardian if one is appointed.

CLIENT'S RESPONSIBILITIES:

- Participate fully in your treatment and recovery.
- Be respectful to the treatment provider and office staff.
- Arrive for scheduled sessions promptly or cancel by telephone as required.
- Provide full information about insurance, status, and any changes to payer status, and assume responsibility for payment as determined by your insurance company or personal payment due to a failure to provide full information about payer status.
- Provide adequate notice if you decide to terminate services and allow for appropriate termination of services.

Your signature(s) indicate(s) that you understand and accept these rights and responsibilities.

Date: _____

_____ _____

Signature of Client/Parent/Guardian **Signature of Child if Client**

_____

Signature of Provider

Lincoln Behavioral Health Clinic

Office Policies

CLINIC HOURS:

Our staffed office hours are Monday through Friday 9:00 am. to 5:00 pm. Outside regular business hours, including holidays, or if the front office is away from the phone, calls will be answered by our answering service and will be triaged as necessary.

RE-SCHEDULING/CANCELLATIONS:

Whenever possible, you will be informed if you need to reschedule/cancel your appointment with as much notice as possible. Our office requests you do the same and make every attempt to contact us should you need to reschedule or cancel.

NO CALL/NO SHOW POLICY:

It is imperative that you let the front office or your provider know as soon as you are aware you will not be able to make your appointment. After a second no call/no show, you will be charged a $50 no call/no show fee for no show appointment(s). Insurance companies do not pay for missed appointments. After a third no call no show, it will be up to your provider's discretion how to proceed. This may include a termination of future services.

EMERGENCY CARE:

We recognize that you may have an emergency situation arise. If it is urgent or life-threatening, please call 911. If it is non-life threatening, our front office staff or answering service will respond as soon as possible.

FEES & PAYMENTS:

You are responsible for the cost of your care. If you are covered by insurance, **your copay is due at time of service** and we will submit your charges to your insurance carrier. If you do not have an insurance carrier, **payment is due at time of service**. In the case of a minor child, the person to whom the monthly statement is to be sent must sign the financial responsibility form.

If your account has a balance of $400.00 or more and no payment plan has been arranged, future services may be restricted to crisis management only. This will be at the discretion of your provider. If there has been no payment activity on your account for 90 days, we reserve the right to begin collection procedures.

RETURNED CHECKS:

There will be a $35.00 service charge added to your account for processing and handling if your check is returned or not honored by your bank.

Date: _____ **Signature:** _____

Signature of Provider: _____

Lincoln Behavioral Health Clinic

Financial Agreement

I,_____(your name), request that Lincoln Behavioral Health Clinic ("LBHC") provide professional services to me/or_____ as (a) client(s).

I have read the LBHC policies for clients (including the documents entitled Authorization to Treat, Insurance Policies, Bill of Rights and Responsibilities, and Office Policies) and agree to cooperate with and abide by all of their provisions as indicated by my signature below.

I agree to make the co-payment due at each session. If after 90 days no payments have been made or I have made no attempts to set up a payment plan, unpaid accounts will be turned over to collection agencies for payment. Such action may result in attorney and/or court fees for which I may be financially responsible. Furthermore, if my account has a balance over $400.00, I understand I will receive only crisis care until a substantial payment is made or a payment plan is set up; the need for such crisis care will be at the determination of my therapist.

I understand that I am responsible for all charges for any service provided by an LBHC therapist to the named client(s), although other persons or an insurance company may make payments on my account. I agree that as long as my account has a balance, reports will not be provided to my attorney, court, myself, and/or any other entity.

I understand that as a client I have the following responsibilities:

- to attend therapy sessions on a consistent basis as determined by myself, and my therapist;
- to cancel my appointments at least 24 hours in advance or I will be personally charged a $50 no call/no show fee. Insurance companies do not pay for uncanceled appointments; nor do they pay for report preparation or report presentations, depositions, court testimony, telephone consults, travel, record review, or copies of records. These requests would be my expense;
- to report any changes of my telephone number, address or insurance carrier to the receptionist at my next visit; and
- to communicate any concerns/questions about my treatment to my therapist.

I have read the above information and give my personal consent to receive psychological/counseling services and agree to my therapeutic and financial responsibilities.

Date: _____

Signature of Person Financially Responsible: _____

Signature of Provider: _____

LINCOLN BEHAVIORAL HEALTH CLINIC

Telehealth Services Informed Consent

Definition of Telehealth:

Telehealth involves the use of electronic communications to enable professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have rights with respect to telehealth:

1. I understand privacy and the confidentiality laws apply to telehealth, and that no information obtained through the use of telehealth services will be disclosed to researchers or other entities without my written consent.
2. My health care provider has explained how the videoconferencing technology will be used to conduct a telehealth session, that unlike a direct patient/provider in person, I will not be in the same room as my health care provider.
3. I understand the potential risks to technology including interruptions, unauthorized access and technical difficulties. I understand my health care provider or I can discontinue the videoconference consult/visit if it is believed videoocnferencing technologies are not adequate for the situation.
4. I understand that I have the right to withold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
5. I undestand that telehealth may involve electronic communication of my personal medical information to other medical practicitoners who may be located in other areas, including out of state.
6. I understand that no results for anticipated benefits can be guaranteed or assured by my provider.
7. I understand my healthcare information may be shared with other individuals for purposes of scheduling and billing. Individuals other than my healthcare provider may be present during the session in order to operate videoconferencing equipment. I further undersand that I will be informed of their presence, and that such individuals will maintain confidentiality on information obtained during the session. Furthermore, I have the right to request the following:
    a. Ask non-medical personnel to leave the telehealth examination room; and/or
    b. Terminate the consultation at any time.

LINCOLN BEHAVIORAL HEALTH CLINIC

Telehealth Services Informed Consent (cont.)

8. I agree certain situations—such as emergencies and crises—are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis-oriented healthcare facility in my immediate area.

Consent to The Use of Telehealth

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that my questions have been answered to my satisfaction.

Client Printed Name: _____

Client Signature: _____ Date:_____

Provider Signature: _____

This form has been adapted from ICANotes Behavioral Health EHR for the purpose of telehealth authorization at LBHC.