ACKNOWLEDGMENTS AND CONSENT FOR TREATMENT
Northeastern Oklahoma Community Health Centers, Inc.

I. CONFIDENTIALITY AND EXCEPTIONS TO CONFIDENTIALITY

Our Organization, (NeoHealth) shall meet the requirements of all applicable state and federal laws, rules, and regulations. Public law 99-401, amends the federal confidentiality laws to require that cases involving suspected, actual, or imminent harm to children must be reported to child protection agencies and therefore are not covered by confidentiality requirements. This applies only to initial reports of child abuse or neglect and not to requests for additional information or records. Court orders are still required before records may be used to initiate or substantiate any criminal charge or to conduct any investigation of a patient.

The behavioral health services are another part of your overall health care. Documentation of your appointment and recommendations from the Behavioral Health Consultant will be written in your electronic medical record at this clinic.

Client records will not be released to other individuals or agencies outside of NeoHealth without your expressed written consent, except upon receipt of a legitimate subpoena, in the event of a valid medical emergency to meet the requirements of state law that child/elderly abuse be reported or in the event you present a danger to yourself or to others.

Since part of the cost of your treatment may be paid by federal, state, commercial, or local sources, these sources have the right to review client files to verify that these services have been delivered appropriately. This review is done for accounting or evaluative purposes only, with no files or clinical information removed from this agency. Others having review access to you file are agency staff, consultants, and accountants.

II. CONSENT FOR TREATMENT

I, We (Parent, legal guardian, if applicable) authorize NeoHealth to administer treatment to me and to continue such treatment as deemed necessary.

I/We hereby authorize counseling and psychological services by any physician, behavioral health consultant, therapist, mental health professional and/or behavioral health rehabilitation specialist authorized by NeoHealth. I/We understand that this consent is given before any specific diagnosis or treatment is required, but is given to authorize the NeoHealth to exercise their judgment in providing treatment.

I/We agree to be actively involved in the treatment as prescribed by the NeoHealth treatment team while I/We receive treatment. I/We understand that included in this

treatment process may be my/our involvement in regular family, individual, or group therapy sessions.

No guarantees have been given by anyone as to the results that may be obtained.

III. TELEHEALTH SERVICES

Telehealth is the use of electronic and telecommunication technologies in the delivery of health related services. Telehealth services provide cost efficient, time efficient, and accessible services to clients unable to access in person services. Studies show that services provided through telehealth for many modalities of therapy are comparable to those provided in person.

When receiving services via telehealth, it is important to remember that your confidentiality remains protected through your provider and NeoHealth through the use of HIPAA compliant software in settings that afford the same privacy as if you were in office; however, your provider and NeoHealth is unable to secure privacy within the setting of the client receiving the services. As the client, you are strongly encouraged to protect your privacy and confidentiality by participating in your scheduled telehealth sessions in a private setting.

While having access to therapeutic services in the setting of our choice may allow for increased feelings of comfort and bring a casual nature to the session, please be mindful of the benefits you seek and maintain a clarity of mind that allows for maximum benefit in the therapeutic experience. This is best achieved by abstaining from mind altering substance prior to session, waking 30 minutes to an hour prior to session, and by removing distractions.

IV. FINANCIAL RESPONSIBILITY AND MISSED OR RESCHEDULED APPOINTMENTS

1. Payment for services (insurance co-payment, the sliding fee plan, or full payment) **is required at the time of your visit**. Cash, personal checks, money orders, or cashier's checks are accepted.
2. If you are uninsured, you may qualify for a discount. **NeoHealth offers a "sliding fee" scale**. A completed and signed application and proof of income (such as a recent income tax form, a W-2 form, or several recent check stubs) provided by you will be used to determine the amount of your discount. You will be **required to re-qualify** for our "sliding fee" scale at least every 3 months to annually.
3. NeoHealth is **not a free clinic** and we must collect from all of our patients in order to continue to provide services to our community. We recognize, however, that on occasion, our patients require financial assistance. An extended payment plan is available to patients who qualify. Please advise if you need to discuss a payment plan with a financial counselor.

4. The patient/parent should **keep their appointments**; a missed appointment takes up time that another patient could use.
5. The patient/parent should **arrive on time** for their scheduled appointment. NeoHealth in turn will work to stay on schedule.
6. If you **fail to appear for an appointment,** any additional **pre-scheduled appointments** with this provider will be **removed from the schedule**.
7. If you **fail to appear for 3 appointments** without notice or demonstrate a pattern that includes **excessive reschedules**, you could be **placed on a 90 day "no appointment hold" with this provider**. A referral may be provided upon request.
8. Should you fail to comply with the above stated responsibilities, NeoHealth reserves the right to reschedule your visit, refer you to another practice, or dismiss you from our practice.

THIS CONSENT SHALL REMAIN IN EFFECT COMMENCING ON THE DATE OF ADMISSION UNTIL THE CLIENT HAS BEEN DISCHARGED; AND FOR THE PURPOSES OF FOLLOW UP, UNLESS REVOKED IN WRITING AND DELIVERED TO NEOHEALTH

ACKNOWLEDGMENTS AND SIGNATURES

1. I/We have received, read, and understand the statement in Section I. (Confidentiality and Exceptions to Confidentiality).

2. I/We have read Section II. (Consent for Treatment), understand all of its contents and sign my/our name(s) freely, voluntarily, and without coercion.

3. I/We have received, read, and understand Section III regarding Telehealth services and consent to receive services via Telehealth unless otherwise noted.

4. I/We agree that I have received, read, and understand Section IV and understand that failure to meet my/our financial obligation and/or participation expectations may result in the rescheduling of my appointment, a 90 day "no scheduling hold" or dismissal from the practice. A referral may be given upon request. I agree to give 24-hour minimum notice of cancellation if not participating in planned services.

_____ _____
Signature of Client (14 or older) Date

_____ _____
Signature of Parent/Guardian (if applicable) Date

_____ _____
Signature of Witness Date

Licensed Behavioral Practitioners
Licensed Marital and Family Therapists
Licensed Professional Counselors

State Board of Behavioral Health Licensure
3815 N. Santa Fe, Ste. 110
Oklahoma City, OK 73118
Telephone: (405) 522-3696
Fax: (405) 522-3691
www.ok.gov/behavioralhealth

STATEMENT OF PROFESSIONAL DISCLOSURE

Please check the appropriate license: ☒ **LPC** ☐ **LBP**

I am required by law to furnish this document to you. It requires that I inform you about my professional training, orientation /techniques, experience, fees and credentials. I am licensed to practice my profession by the State Board of Behavioral Health Licensure.

My license number is **LPC** 6374 **LBP** _____

The licensing website is **www.ok.gov/behavioralhealth** where you can access the law and regulations which govern my license. I will furnish you with printed materials about the requirements of my licensure if you so desire. You may contact (without giving your name), the State Board of Behavioral Health Licensure at:

State Board of Behavioral Health Licensure
3815 N. Santa Fe, Ste. 110
Oklahoma City, OK 73118
Telephone: (405) 522-3696
www.ok.gov/behavioralhealth

Licensee's Printed Name: Allie Grantham, MHR, LPC

Licensee's Signature: _____ **Date:** _____

The above-designated licensee has satisfactorily supplied me with information regarding his/her practice, licensure and professional development.

Client's Signature: _____ **Date:** _____