S&H Youth and Adult Services, Inc.
714 S Main St Salisbury NC 28144
5736 N Tryon Charlotte NC 28213
SHYAS.COM | 866-495-3651 | 704-353-7901

SHYAS
Your Place of Security & Hope

# Welcome to S&H Youth and Adult Services

S&H Youth and Adult Services, Inc dedicated providers and staff are committed to ensuring that you receive the highest quality behavioral health services possible. This Patient Agreement establishes guidelines for your participation in treatment with us. Please read the entire Agreement and ask staff if you have any questions.

**Initial Evaluations/Annual Evaluations**
A psychiatric evaluation, medication evaluation, or comprehensive clinical assessment is a clinical interview conducted by the provider at the beginning of treatment and yearly thereafter, to diagnose behavioral health problems and/or to determine if medication is appropriate for treatment. The evaluation is usually a 45-90 minute session. The purpose of this session is to obtain a detailed history and perform a comprehensive examination. Your (or your child's) provider may request information from other health care providers and school before making a definitive diagnosis and/or treatment recommendations.

**Follow-Up Sessions**
Following the initial evaluation, your (or your child's) provider will discuss their assessment with you and make recommendations regarding treatment (medication(s), psychotherapy, peer support, etc.). Your provider may request a blood test or an EKG prior to starting you on a particular medication. If your provider determines medication is appropriate for your treatment, our staff will schedule you for follow-up sessions as indicated during the initial phase of treatment. In these sessions, your provider will carefully monitor your (or your child's) response to the medication(s) prescribed and any side effects. These follow-up sessions typically last 15-30/60 minutes, although they may take somewhat longer in the early stages of treatment.

**Regular Attendance**
The relationship between a provider and his/her patient is a partnership and regular attendance at appointments is a critical part of your care. Although regularly scheduled visits with your provider may at times feel burdensome, this commitment helps ensure that you receive the highest quality care possible.

**Late Arrivals**
If you arrive late for a scheduled appointment and your provider determines that there is enough time remaining, they will see you for the remainder of your appointment time. That said, your provider may also request that you schedule an additional appointment with them.

**No Show & Late Cancellation Policy***
We reserve your appointment time specifically for you and you alone. Med Clinic Appointments canceled with less than (2) business days' notice may be subject to a fee. Please be advised that after you no show to or late cancel three (3) scheduled appointments, your provider may terminate their relationship with you. We also understand that your time is valuable. For this reason, our office staff will call or text you to remind you of scheduled appointments.

**Children and Appointments**
Please note a parent, guardian, or caretaker should be with children in our waiting area at all times. Parent, guardian, or caretaker must be present for all psychiatric services.

**Emergencies and Urgent Consultations**
For your benefit, a staff person will be available each day after office hours in case of a behavioral health crisis emergency. Our office is open Monday-Friday from 8:30am-5:00pm. After hours on-call staff can be reached by calling our office directly (866-495-3651) and following the prompts. In the event of a life-threatening emergency, please call 911 or go directly to the emergency room.

**Medications**
Our providers typically evaluate adults for one session and children for up to two sessions before determining whether medication is indicated for care. For child patients, the decision to start a medication may not be made during the first session and may be deferred until the child's second session to allow the provider adequate time to obtain a full history and review any requested medical or school records.



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**To ensure the best response to any prescribed medications, please observe the following procedures:**

- Always notify your provider of any side effects or problems with medications you are experiencing.
- Never stop or change the dose of a medication without first discussing it with your provider.
- Suddenly stopping medication can cause medical problems. For this reason, do not allow yourself to run out of medication.
- If you need a refill before your next scheduled appointment please call our office one week prior to running out of your medication.
- Keep your scheduled appointments. Although your provider will prescribe you adequate medication until your next visit, canceled or missed visits can prevent you from having sufficient amounts of medication and make it difficult for your provider to monitor your progress and any complications.
- If you do cancel or miss a visit, be sure to reschedule your next visit before you run out of medication.

I have accessed, read, and understand my rights and responsibilities. I have been provided access to download a copy of the Service Recipient Handbook. By signing this form, I confirm that I read the orientation and written documentation by S&H Youth and Adult Services, Inc. that includes the following policies and procedures:

- Program Descriptions/Service Definitions
- Admission and Discharge Policy
- Provider Choice
- Person Centered Plan
- Client Rights and Responsibilities
- Notice of Privacy Practices
- Complaints and Grievance
- Confidentiality
- First Responder Crisis Response
- Record Management
- Suspension and Expulsion
- Search and Seizure
- Physical Restraints/Interventions
- Transportation

**I have read and agree to this Patient Agreement in its entirety**

I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent is valid from _____ to _____ (mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

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| _____ | _____ |
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# Consent to Treatment

I am voluntarily seeking behavioral health services, including medication management, MAT, and/or psychotherapy, from S&H Youth and Adult Services, Inc for the purpose of diagnosis and treatment, and recovery services. I hereby consent to such examinations, treatments and/or diagnostic procedures as may be deemed advisable by my treating provider.

I understand that S&H Youth and Adult Services, Inc providers include psychiatrists, psychiatric mental health nurse practitioners, physician assistants, psychologists, licensed therapist, certified substance use counselors, and peer support specialist. I understand that there are both risks and benefits to psychiatric treatment. I am aware that all medical care, including psychiatric care, substance use treatment, peer support and psychotherapy, is not an exact science and I acknowledge that no guarantees have been made as to the result of such examinations, treatments and/or diagnostic procedures. I also understand that while the course of my treatment is designed to be helpful, it may at times be difficult or uncomfortable.

Managed Mental Health Care: I understand that my treatment is being paid for in full or in part by a managed care firm and there are limitations to my rights as a client imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to me, to decide the time period within which I must complete therapy or to require me to use medication if their reviewing professional deems it appropriate. They require detailed reports of my treatment progress and copies of your case file. SHYAS staff do not have control over any aspect of their rules. SHYAS staff will maximize the benefits I receive by filing necessary forms and gaining required authorizations for treatment.

Client Rights and Responsibilities: I understand I have access to the handbook that explains Privacy Practices, Rights; Confidentiality; Recipient Responsibility; and policy and procedures that include Grievance, Search and Seizure, and Suspension and Expulsion. I understand that I may ask questions or concerns. I understand all recipient information is confidential and may not be divulged to any person, or agency outside S&H Youth and Adult Services, Inc without authorization. I understand I have the right to provider choice. I may decide not to work with S&H Youth and Adult Services, Inc and leave services at any time.

My signature signifies the offer of provider choice and receipt of handbook. My signature confirms I have access to read the written documentation that includes the following policies and procedures: Program Descriptions/Service Definitions; Admission and Discharge Policy; Provider Choice; Person Centered Plan; Client Rights and Responsibilities; Notice of Privacy Practices; Complaints and Grievance; Confidentiality; First Responder Crisis Response; Record Management; Suspension and Expulsion; Search and Seizure; Physical Restraints/Interventions; and Transportation. I understand that I may ask questions about anything I have read and request an explanation to my understanding by a qualified employee.

My signature confirms I understand that if I, the patient is a minor under the age of 21 or has a legal guardian, the parent, guardian, or caretaker must sign to consent to treatment on the patient's behalf. I must indicate my authority and sign below. I also understand that if I share legal custody of the patient, by signing this consent form I am representing that all parties who have legal custody of the patient have been made aware of, and consent to the patient's treatment. I understand that if I am my own legal guardian, I have the right to alone consent to outpatient behavioral health treatment with S&H Youth and Adult Services, Inc and therefore must sign this consent form in order to be treated by S&H Youth and Adult Services, Inc.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand that I have the right to withdraw my consent to treatment at any time. I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent is valid from _____ to _____ (mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

_____ _____
Patient/Guardian Signature Date

_____ _____
Patient Name Patient Date of Birth



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# Acknowledgment of Financial Responsibility & Credit Card Authorization

I hereby assign payment of my insurance benefits to S&H Youth and Adult Services, Inc and authorize S&H Youth and Adult Services, Inc to disclose my health information to my insurance company in order to obtain payment for services rendered to me. I understand that I/the legal guardian am financially responsible for all charges not covered by an insurance plan, including copays and deductibles and no show and late cancellation fees, which are due at the time of the visit.
I understand that S&H Youth and Adult Services, Inc does not accept checks. All payments must be made by cash, credit, or money order. I authorize S&H Youth and Adult Services, Inc to keep my credit card information below on file and charge my credit card for amounts owed by me. I understand that I will be sent receipts for credit card charges via mail or e-mail and that such charges will appear on my credit card statement.

**Insurance and Credit Card Information**
I understand that I am responsible for providing S&H Youth and Adult Services, Inc with accurate and complete insurance information. I also understand that I am required to notify S&H Youth and Adult Services, Inc of any changes in my insurance coverage or credit card information and will be personally responsible for the cost of my care if I provide inaccurate or incomplete insurance information to S&H Youth and Adult Services, Inc or my coverage or credit card lapses.

I understand that if my behavioral healthcare is paid for in full or in part by a managed care firm, there are limitations to my rights as a patient imposed by the contract of the managed care firm. These may include their decision to limit the number of treatment sessions available, to decide the time period within which the patient must complete treatment, to require you to use medication if their reviewing professional deems it appropriate. They require detailed reports of your progress in treatment, & copies of your case file. S&H Youth and Adult Services, Inc does not have control over any aspect of their rules. S&H Youth and Adult Services, Inc will maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment.

**Past Due Balance**
I understand that if I have a past due balance, I may establish a payment plan with S&H Youth and Adult Services, Inc , with which I must comply in order to continue to be seen by my provider. I understand that S&H Youth and Adult Services, Inc requires me to keep a balance of under $100 in order to continue to be seen by my provider and that if I fail to do so, I may be terminated by my provider for non-payment.I understand that this Acknowledgement of Financial Responsibility & Credit Card Authorization may be revoked at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent is valid from _____ to _____ (mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

Name of Credit Card Holder Date

/

Credit Card Number Exp. Date (mm/yy) Security Code Zip Code

Patient/Guardian Signature Date

Patient Name Patient Date of Birth



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# Approved Interventions

I understand that S&H Youth and Adult Services, Inc DOES NOT PERMIT PHYSICAL RESTRAINTS. S&H Youth and Adult Services, Inc permits its staff to use certain specific interventions to contain aggressive or threatening behavior displayed by patients. I understand the following interventions have been approved for use of S&H Youth and Adult Services, Inc.

Voluntary Time Out. S&H Youth and Adult Services, Inc employs a treatment approach that is based on positive reinforcement and least restrictive techniques (hands off) for the containment of aggressive behavior. When imminent danger is present, S&H Youth and Adult Services, Inc staff may ask the patient to take a voluntary time out.

Therapeutic crisis Response (ICV/Mobile Crisis). The SHYAS therapeutic crisis response may also be employed for approved clinical treatment reasons and used as an approved intervention by the consumer or legal guardian and consumer's treatment team. When/if therapeutic crisis response is necessary to manage dangerous behaviors, S&H Youth and Adult Services, Inc will follow its policy of notification of the legal guardian (if applicable) and other designated persons within specified time period.

☐ I authorize S&H Youth and Adult Services, Inc to use intervention techniques of observation, audio/video taping during the course of my treatment for the purpose of supervision, training, research, and quality assurance and improvement of Service.

☐ I authorize S&H Youth and Adult Services, Inc to use intervention techniques of photography during the course of my treatment for the purpose of marketing, service recording, supervision, training, research, and quality assurance and improvement of Service.

☐ I authorize S&H Youth and Adult Services, Inc to use intervention techniques of Transportation during the course of service for treatment purposes access to care, supervision, training, research, and quality assurance and improvement of Service.

I understand that S&H Youth and Adult Services, Inc must use the intervention techniques of Record-keeping during the course of my treatment for the purposes maintaining clinical documentation (everything staff does with, for, and on behalf of the patient). Staff will keep records of what interventions happened during visit or session, the topics discussed, and the patient's response to the intervention and topics discussed.

I understand that under the provisions of the Health Care Information Act of 1992, I have the right to a copy of my file at any time. I have the right to request that staff correct any errors in the file. I have the right to request that I make a copy of the file available to any other health care provider with a written request.

I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent is valid from _____ to _____ (mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

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Patient/Guardian Signature | Date

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# E-Mail and Text Authorization

I hereby request that S&H Youth and Adult Services, Inc communicate with me regarding my treatment via electronic mail, text, or e-mail.

I understand that this means S&H Youth and Adult Services, Inc staff will transmit my protected health information, such as information about my appointments, diagnosis, medications, progress, and other individually identifiable information about my treatment, via e-mail. I understand there are risks inherent in the electronic transmission of information by text or e-mail, and that such correspondence may be lost, delayed, intercepted, corrupted, altered, rendered incomplete or undelivered. I further understand that any protected health information transmitted via e-mail pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error free and its confidentiality may be vulnerable to access by unauthorized third parties, neither S&H Youth and Adult Services, Inc nor my provider shall have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the text or e-mail of information by S&H Youth and Adult Services, Inc to me.

After being provided notice of the risks inherent in the use of text or e-mail to transmit protected health information, I hereby expressly authorize S&H Youth and Adult Services, Inc to communicate via text or email with me, which will include the electronic transmission of my protected health information. I understand that this E-Mail and Text Authorization will remain in effect until I revoke it by submitting a notice to S&H Youth and Adult Services, Inc in writing.

I hereby authorize the transmission of my protected health information via e-mail or text as described above. I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent is valid from _____ to _____ (mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

| | |
|---|---|
| Patient Signature | Date |
| Patient Name | Patient Date of Birth |
| Email Address | Text/Mobile/Cell Phone# |

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# Consent to Telemedicine – Obtain Medication History

I hereby consent to the use of telemedicine/telehealth services by S&H Youth and Adult Services, Inc. I understand that telemedicine/telehealth services involves the communication of my medical information, both orally and visually, to providers involved in my treatment who are located at a different site than me. I understand I have all of the following rights with respect to telemedicine:

***Patient Choice.*** I have the right to withhold or withdraw my consent to tele services at any time without affecting my right to future treatment.

***Access to Information.*** I have the right to inspect and receive copies of all medical information transmitted during a telemedicine consultation. I understand that my telemedicine/telehealth provider will communicate my relevant health information to physicians and other health care practitioners involved in my treatment who are located in different offices or clinics, such as my peer support specialist, counselor, primary care physician or therapist.

***Confidentiality.*** I understand that the laws which protect the confidentiality of medical information apply to telemedicine, that I will not be recorded, and that no information from my telemedicine consultations which identifies me will be disclosed to third parties without my consent.

***Potential Risks.*** I understand that there are potential risks associated with telemedicine, including disruption or distortion in the transmission of medical information and unauthorized access to medical information generated, transmitted, and stored pursuant to the telemedicine consultation. I understand that telemedicine/health service is an alternative to in-person treatment and S&H Youth and Adult Services, Inc may recommend I discontinue telemedicine and receive in-person treatment in certain circumstances. I understand that telemedicine does not negate or minimize the risks that may be inherent to my illness or condition and that there may be other risks associated with telemedicine that are not listed here.

***Benefits.*** I understand that I can expect benefits from telemedicine, but that no particular results can be guaranteed. I understand that telemedicine may provide me with access to behavioral health services that otherwise would not have been available to me.

***Consent to Obtain Medication History.*** S&H Youth and Adult Services, Inc uses an electronic platform in its EHR to electronically prescribe medications to patients. Using this platform, providers can transmit prescriptions to a patient's desired pharmacy electronically from the point-of-care. EHR also allows providers to obtain a patient's prescription medication history upon their consent. This information helps providers to identify potential medication issues, such as drug interactions and duplicate prescriptions.

I hereby authorize S&H Youth and Adult Services, Inc to request and use my prescription medication history collected from other healthcare providers, third-party payers (i.e. my insurance company), and pharmacies for treatment purposes. I understand that this Consent to Obtain Medication History will remain in effect until I provide written notice of cancellation to S&H Youth and Adult Services, Inc.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand that I may revoke this consent at any time except to the extent that the agency which is to release information has already taken action in reliance on it. If not revoked sooner, this consent is valid from _____ to _____ (mm/dd/yy) (not to exceed one year from date of signature) or specified event or condition which may include termination of services, of whichever is earlier.

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