Barnabas Behavioral Healthcare, LLC

Specializing in the Strategic Integration of Behavioral and Medical Care

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The following form will become part of your confidential record. Please answer each question as carefully as you can. You may use the back of any page for additional comments

Date _____ Name _____ Date of Birth _____ Age _____ Sex _____

Present address _____

Telephone Home _____ Work _____ Mobile _____

Social Security Number _____ EMAIL _____

Emergency Contact _____

Their address _____

Their phone _____

Marital status _____ If married, number of years____ Number of Marriages ____

If separated/divorced, how long? _____

Living with Spouse ____ Roommate ____ Alone____ Parents____ Children ____

Occupation _____ Hours per week _____

Employer _____

Highest Level of education completed Major

Religious Affiliation _____ Number of times you attend religious services per month _____

Explain your spiritual beliefs _____

Name of primary care provider (M.D., N.P., or P.A.) _____

Address _____ Phone _____

Are you currently receiving medical treatment? Yes ____ No ____ Please describe any problems you have that require medical or physical care _____

Have you previously had counseling/therapy? Yes ____ No ____ When? _____ How long? _____ With whom? _____

Why did you stop? _____

Do you use or have you used any of the following (how much, how often, and for how long?

Cigarettes _____

Alcohol _____ Family Members _____

Other Substances _____ Family Members _____

List any family history of mental illness _____

List any drug or food allergies you may have _____

FAMILY MEMBERS

	Name	Age	Occupation or grade in school
Spouse			
Children			
Stepchildren			
Father			
Mother			
Siblings			

Problem Areas: In the following list, please place a check next to each item which indicates an area of concern to you. Please place two checks by items which are most important (you may add comments.)

_____ Anxiety
_____ Depressed mood
_____ Guilt feelings
_____ Over activity
_____ Weight loss
_____ Weight gain
_____ Headaches
_____ Feelings of inferiority
_____ Loss of interest
_____ Poor sleeping
_____ Repetitive ideas
_____ Thought of suicide
_____ Wish to hurt others
_____ Marital relationship
_____ Financial problems
_____ Lonely/too few friends
_____ Unhappy most of the time
_____ Problem with children
_____ Troubling memories
_____ Inability to relax
_____ Memory difficulties
_____ Lack of confidence
_____ Can't make decisions
_____ Bitterness or resentment
_____ Periods of over activity
_____ Eating problems
_____ Shy or awkward with others

_____ Unable to trust others
_____ Change in eating habits
_____ Fighting/arguing with others
_____ Can't stand up for myself
_____ Can't say "no" to others
_____ Poor adjustment to job/school
_____ Bad temper/anger problems
_____ Difficulties with opposite sex
_____ Stomach or bowel disturbance
_____ Unfairly treated by others
_____ Repetitive behaviors
_____ Drinking or drug problems
_____ Rely too much on others
_____ Suspicious of others
_____ Recent loss of someone
_____ Sexual problems/concerns
_____ Family quarreling
_____ Fearful of things or situations
_____ Religious/spiritual concerns
_____ Cardiovascular /heart problems
_____ Alcohol/drug problem in family
_____ Unusual/strange experiences
_____ Stress from recent event
_____ Divorce/separation difficulty
_____ Troubling habits/thoughts
_____ Feeling rejected by family
_____ Other (specify)

In your own words, briefly describe the main problem(s) which prompted you to seek help at this time.

_____

_____

_____

Have there been times when the problem(s) got better or disappeared? Yes_____No_____ _

If so, when_____

_____

What do you think helped?_____

_____

Were there times when the problem was especially bad? Yes_____ No_____ If so, when? _____

What made it bad? _____

_____

Are there other people who play a role in causing your problem? _____

Helping your problem?_____ Explain briefly_____

_____

_____

Name the main goal that you would like to reach in counseling _____

_____

_____

_____

How did you hear about our center? _____

_____

Medical History

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Patient Medical History

- ☐ Headache
- ☐ Shortness of Breath
- ☐ Heart Palpitations
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Dizziness/Fainting
- ☐ Peripheral Vascular Disease
- ☐ Allergies/Hay fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Ulcer
- ☐ GI Disorder
- ☐ Lactose Intolerance
- ☐ Gallbladder Disease
- ☐ Prostate Problems
- ☐ Bowel Irregularity
- ☐ Incontinence
- ☐ Overactive Bladder
- ☐ Frequent Urination
- ☐ Sexual/Menstrual Dysfunction
- ☐ Venereal Disease
- ☐ Frequent Infections
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Nervousness
- ☐ Depression
- ☐ Gout
- ☐ Scarlet fever
- ☐ Chronic rashes
- ☐ Rheumatic fever
- ☐ Mumps
- ☐ Measles
- ☐ Rubella
- ☐ Polio
- ☐ Diphtheria
- ☐ Tetanus

Medications

Please CLEARLY list any current medications you are taking	**Strength**	**Dose**	**Frequency**
Example- Zithromax Z-Pack	*250 mg*	*2 Pills*	*Daily*

Please list clearly any allergies as it related to medications

Example -Penicillin

Preferred Pharmacy Name

Phone Number

Address

Primary Care Doctor

Fax Number

Referring Provider

Fax Number

The Mood Disorder Questionnaire

Name: _____ Date: _____

Instructions: Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	Yes	No
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke much faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family into trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	◯	◯

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please select one response only.

◯ No Problem ◯ Minor Problem ◯ Moderate Problem ◯ Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness " " or bipolar disorder?	◯	◯

Generalized Anxiety Disorder Questionnaire (GAD-7)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Feeling nervous, anxious or on edge?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
2. Not being able to stop or control worrying?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
3. Worrying too much about different things?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
4. Trouble relaxing?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
5. Being so restless that it is hard to sit still?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
6. Becoming easily annoyed or irritable?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
7. Feeling afraid as if something awful might happen?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

The GAD-7 score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of 'not at all', 'several days', 'more than half the days', and 'nearly every day', respectively, and adding together the scores for the seven questions.

0 Points	Not at all
1 Point	Several days
2 Points	More than half the days
3 Points	Nearly every day

TOTAL SCORE

_____

Barnabas Behavioral Healthcare, LLC

Payment & Insurance Information

As a courtesy to our patients, we can file your bill to your insurance company. It's much easier for the both of us if we have the right information up front. If you have questions about how the billing process works, feel free to call or browse through our frequently asked questions page on our website.

A word of protection for our patients:

- Your treatment with us may be covered by a different insurance than a visit with your family doctor.
  You can usually find on the back of your insurance card the mental/behavioral health phone number if you are unsure.
- Some providers may NOT be in network with your insurance company.
  You can contact your insurance company and give them the name of the provider you are wanting to see.

We do our best to schedule your appointment with an In Network provider, however we have found that certain insurances outsource their mental health coverage processing to a completely different company (Blue Cross Plan XYZ may cover a primary care physician office visit while sending mental health claims to United Behavioral Health Plan ABC). The issue with this is while your provider may in fact be In Network with the insurance company named on your card, they may out of network if the claims are sent elsewhere.

In our example above, the provider was not in network because the mental health coverage is with a different company. Most of the time, it is easy for us to determine if this is case and generally there are only a few insurance companies that do this. We strongly recommend that you speak with your insurance company to determine where the mental health (sometimes referred to as behavioral health) coverage is processed. *We will pass on to you what your insurance tells us you owe*. This means that if the insurance company tells us we have the wrong company, the wrong date of birth, the wrong ID etc., or to apply out of network coverage, you will be responsible for the payment according to your coverage.

Please note, some visits will require an authorization and/referral. We know that Humana will require your primary care physician to send us a referral to treat you. Some psychological testing may require approval prior to your visit.

Please fill out the areas below as accurately as possible:

EMAIL or Fax or Send or Bring a copy of your insurance card(s)
Email- appointments@barnabashealthcare.com
Fax- 803.216.0420

Patient Name: _____ Patient Date of Birth: _____
Primary Insurance: _____ Patient SSN: _____
Insurance ID: _____
Insured By: _____ Relationship to Insured: ___ Self
Insured by Date of Birth: _____ ___ Spouse
Insurance Address: _____ ___ Child
Mental Health Phone: _____ ___ Other:

Secondary Insurance: _____
Insurance ID: _____
Insured By: _____ Relationship to Insured: ___ Self
Insured by Date of Birth: _____ ___ Spouse
Insurance Address: _____ ___ Child
Mental Health Phone: _____ ___ Other:

AUTHORIZATION FOR PAYMENT

For convenience, we offer different payment options. You can call us after your visit to pay over the phone, pay through the patient portal or we can store a credit card on file for you. If you have any questions about your balance, feel free to call our billing team or send a message through the portal. We will not schedule follow up visits with an outstanding patient balance. Standing appointments require a zero balance weekly or to have a card on file for payment. If you would like to setup a card on file, please fill out the following information. If you chose to place a maximum debit amount and have any questions regarding what your portion of your bill will be (self pay or insurance), we are happy to help.

Please select from the following payment options.

____ I will make my payments by mail
____ I will make my payments through the patient portal
____ I will make my payments over the phone with a credit card
____ I will make my payments in person with cash/check/credit card
____ I will make my payments with the following card on file.

Card on File for Payment Information

Card Number:	_____	Type of Card:	_____
Name on Card:	_____	Expiration Date:	_____
Billing Address:	_____	CITY/STATE/ZIP:	_____
	_____	CVV:	_____

Please indicate your preference.

INITIALS ___I give permission to Barnabas Behavioral Healthcare, LLC to bill my credit card on file

___I give permission for a monthly payment

___I give permission for a biweekly payment

___I give permission for a weekly payment

INITIALS ___Debit my account for patient responsibility balance

___Full Balance

___Up to Maximum Debited $_____

_____ _____

Signature Date

Agreement for Services

Barnabas Behavioral Healthcare, LLC

Please read the following Agreement for Services carefully and initial each page sign at the end of agreement.

Introduction and Informed Consent

Welcome to Barnabas Behavioral Healthcare. This document outlines the agreement between you as a patient and our practice. Please read the following carefully and let us know if you have any questions. By signing this consent, you agree to be treated by our practice and pay for our services. We have also included our privacy practices notice and controlled substances agreement. Please read carefully and discuss any questions you may have with your provider.

Non-Acute Care Setting

Barnabas Behavioral Healthcare is a non-acute care outpatient clinic. This means that we do not provide 24-hour coverage like inpatient centers or hospitals. Our office hours are 8-5 Monday through Friday, and we may be closed for some holidays. Messages sent after hours will not be seen until the next business day. We require 72 hours to respond to routine inquiries through our portal system or through our office. In case of emergencies, go directly to the Emergency Room or call 911.

We are excited to be your provider and help you along your treatment goals, however you are not considered a patient with us until you have met with one of our licensed providers for an intake session. We will not prescribe medications or complete paperwork until after our assessment in a diagnostic interview.

Nature of Services

We offer both ***telehealth*** and ***in-person*** visits for treatment. Telehealth involves using electronic communications to deliver healthcare services when the provider and patient are not in the same location. This can include consultation, diagnosis, treatment, and the transfer of medical data. In-person visits allow for face-to-face interaction and may be preferred for certain assessments or treatments.

Practice Communication

You can reach our office through the patient portal, via email, or by leaving a message. Please allow up to 3 business days for a response. To ensure efficient service, kindly refrain from leaving multiple messages regarding the same issue. For prescription status updates, please check directly with your pharmacy.

Frequently asked questions and practice information can be found at our website-

www.barnabashealthcare.com

Telehealth Informed Consent

Benefits of Telehealth

•Increased access to care, especially in remote or underserved areas

•Convenience and reduced travel time

•Continuity of care when in-person visits are not possible

Potential Risks of Telehealth

•Technology failures can disrupt or delay services- in the event of a technical issue such as an internet outage or poor connectivity, please call our office at 803.216.0850. Our providers will try to call you to reconnect, however the call may come from a blocked number.

•Confidentiality breaches may occur despite security measures

•Telehealth may not be appropriate for all patients or situations

•There may be limitations to the provider's ability to assess or treat you remotely Confidentiality and Data Security

Patient Responsibilities

•Ensure you have the necessary technology and a reliable internet connection for telehealth sessions

•Participate in telehealth sessions from a private, quiet location

•Attend scheduled in-person appointments as agreed upon with your provider

•Inform your provider of any changes in your contact information

•Follow your provider's instructions and participate actively in your treatment

Your privacy and confidentiality are very important to us. Telehealth sessions will be conducted using secure, encrypted platforms to protect your personal information. However, there is always a risk of unauthorized access. Please ensure you are in a private location during your sessions.

Initials_____/Date_____

Financial Policy

Patients are responsible for all deductibles, co-payments, coinsurance, and non-covered charges. We will call your insurance to get a description of benefits, but we are not responsible for incorrect benefit information given to us by your insurance carrier or changes in coverage after verification. A description of benefits is not a guarantee of coverage. In the event of non-payment by your insurance company, the charges on your account will be your responsibility. Payment is due at the time service is rendered. We accept Visa, MasterCard, Personal Checks, Cash, and payment through the patient portal.

All co-payments are collected before the time of service. You are encouraged to verify your insurance benefits directly with your insurance company.

Paperwork for FMLA, disability determination and any other documentation requiring provider time outside of a visit will carry a charge depending on the time requirement and complexity of the work. Please ask your provider about the cost for completing documentation prior to having them complete the work.

No Show/Late Cancellation Policy

If you cannot make your appointment, please inform us in advance so we can offer your slot to another patient. We require 24 hours' notice for a cancellation without charge. For example, if your appointment is at 8 AM on Monday, you need to call us before 8 AM on Friday to cancel without a fee.

- First No-Show/Late Cancellation: $50.00
- Second No-Show/Late Cancellation: $100.00 and possible forfeiture of standing appointment slots
- Additional No-Show/Late Cancellation: $100.00 and possible termination from our practice

Your insurance company will not pay for no shows. We will do our best to send reminders of your appointment time as a courtesy.

Mental Health Coverage

As a patient of Barnabas Behavioral Healthcare, it is your responsibility to promptly inform our practice of any changes to your insurance information. Keeping your insurance details up-to-date ensures that your coverage is verified and that billing processes are accurate and timely. Failure to provide current insurance information may result in delays or denials of claims, and you may be held responsible for any charges incurred. Please notify our office immediately if there are any changes to your insurance provider, policy, or coverage.

Please check the back of your insurance card to determine where the claims need to be filed for your mental health coverage. Some insurance policies may have a third party for mental health benefits. It is also advised to verify if your provider is in-network with your mental health coverage.

Initials_____/Date_____

NOTICE OF PRIVACY PRACTICES

Patient Health Information (PHI)

Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protecting the privacy of your PHI.

Psychotherapy Notes

The HIPAA privacy rules give special protection to psychotherapy notes which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

How we use your patient health information (PHI)

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

Treatment: We will use and disclose your PHI to provide you with medical/psychological treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members that you have indicated with a signed release of information.

Payment: We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

Operation: We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

Special Situations that DO NOT require your permission: We may be required by law to report suspected abuse or neglect, homicidal or suicidal intent; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services. In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

Individual Rights

You have certain rights with regard to your PHI, for example:

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility or it can be downloaded from our website. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

Records Request and Psychotherapy Notes

In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies. If you believe the information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request.

Unless agreed upon by your provider, we will not allow access to psychotherapy notes. For additional findings related to the Privacy Rule and disclosure of mental health please visit *https://www.hhs.gov/sites/default/files/hipaa-privacy-rule-and-sharing-info-related-to-mental-health.pdf*

Our Legal Duty

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the admissions area and on our website at www.barnabashealthcare.com. You can also request a copy of our Notice at any time. If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the Privacy Officer listed below.

Barnabas Behavioral Healthcare, LLC
Attn: Privacy Officer
409 Evelyn Dr
Columbia, SC 29210

Initials_____/Date_____

Controlled Substances Agreement

PATIENT CONTRACT BETWEEN BARNABAS BEHAVIORAL HEALTHCARE, LLC AND PATIENT WHO ARE PRESECRIBED ANY CONTROLLED SUBSTANCES

The purpose of this contract is to protect your access to controlled substances and to protect our ability to prescribe to you.

The long-term use of such substances as opioids (Narcotic pain medicines) benzodiazepine (Xanax, Klonopin), and stimulants (Adderall, Ritalin, etc.) barbiturate sedatives (Ambien, Halcion) is controversial because it is not certain whether they help patients over the long term. Patients who are prescribed these drugs have some risk of developing an addictive disorder developing or suffering a relapse of a prior addiction. The extent of this risk is not certain.

Because these drugs can be abused by the patients who receive them, or by others, it is necessary to observe strict rules when they are prescribed over the long term. For this reason, we require each patient receiving long-term treatment with these medications to read and agree to the following policies.

It is agreed by you, the patient, as consideration for, and a condition of, the willingness of the physician/nurse practitioner whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat your condition.

1. All controlled substances must come from a physician/nurse practitioner in this office. My controlled substances will come from the physician/nurse practitioner whose signature appears below, or during his or her absence, by the covering prescriber unless specific authorization is obtained for an exception.

2. I will inform any physician of any current or past substance abuse, or any current or past substance abuse of any immediate member of my immediate family.

3. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, I will inform all my providers in advance.

4. I will inform the office of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.

5. I agree that my prescribing physician/nurse practitioner has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide health care for purposes of maintaining accountability.

6. I will not allow anyone else to have, use, sell, or otherwise have access to these medications.

7. I understand that tampering with a written prescription is a felony, and I will not change or tamper with my doctor's written prescription.

8. I will take my medication as prescribed, and I will not exceed the maximum prescribed dose.

9. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes will likely develop.

10. I will cooperate with unannounced urine or serum toxicology screens as may be requested.

11. I understand that the presence of unauthorized substances may prompt referral for assessment for a substance abuse disorder or discharge from the practice.

12. I understand that these drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.

13. I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication, I will be required to complete a statement explaining the circumstances. At that time, a determination will be made as to whether I may receive an early refill. If I request an early refill secondary to lost, damaged, or stolen prescriptions twice within a year I will possibly be discharged from the practice.

14. I understand that a prescription may be given early if the physician or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescription(s) may not be filled prior to the appropriate date.

15. If the responsible legal authorities have questions concerning my treatment, as may occur, for example if I obtained medication at several pharmacies, all confidentiality is waived, and these authorities may be given full access to my full records of controlled substances administration.

16. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician/nurse practitioner or referral for further specialty assessment.

17. I will keep my scheduled appointments in order to receive medication renewals. No refills will be given out by phone, fax, at night or on weekends.

18. I understand that any medical treatment is initially a trial, and that continued prescription is contingent on whether my physician/nurse practitioner believes that the medication usage benefits me.

19. I have been explained the risks and potential benefits of these therapies, including, but not limited to psychological addiction, physical dependence, withdrawal, and over dosage.

20. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept all of the terms.

21. I am aware that attempting to obtain a controlled substance under false pretenses is illegal and I will be terminated from treatment at Barnabas Behavioral Healthcare, LLC.

Initials_____/Date_____

Consent to Services

By signing this agreement, you acknowledge that you understand the following:

- You have the right to withhold or withdraw consent to telehealth services at any time without affecting your right to future care or treatment.
- You understand the potential risks and benefits of telehealth.
- You understand the limitations of our non-acute care setting
- You agree to participate in telehealth and/or in-person services under the terms described above.
- You understand and agree to our No Show/Late Cancellation Policy
- You understand and agree to that payment is due at the time of service
- You have been given a copy of our privacy practices
- You have read and agree to our controlled substances contract

Patient Consent

I hereby give consent for medical treatment for myself, or I am duly authorized by the patient to consent to such treatment.

Assignment of Benefits

I hereby authorize payment for medical benefits directly to the provider of the services rendered.

Release of Information

I hereby authorize the release of any medical information necessary to process insurance claims.

Controlled Substances Agreement

I hereby agree to the controlled substances agreement between patients receiving a controlled substance and Barnabas Behavioral Healthcare, LLC.

Privacy Practices Acknowledgement

I have received and understand the privacy practices of Barnabas Behavioral Healthcare, LLC

Signatures

Patient Name: _____

Patient/Legal Guardian Signature:_____

Signed Date: _____