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: _____