PATH
Behavioral Healthcare

HEALTH ACKNOWLEDGEMENT OF PATIENT FINACIAL RESPONSIBILITY

Client Name: _____

DOB:_____

Guarantor Name:_____

DOB:_____

PATH Behavioral Health appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our stated fees. Please reference our fee schedule for a detailed listing of our services and corresponding fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to PATH Behavioral Health for providing services to me or the above-named client. I acknowledge that this only represents currently planned services and that additional services may be offered based upon clinical recommendation. PATH Behavioral Health will notify me and gain approval prior to offering any additional services.

I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to PATH Behavioral Healthcare, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Co-Pay/ Co-Insurance Policy

Some health insurance carriers require the patient to pay a co-pay I Co-insurance for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Consent for Treatment and Authorization to Release Information

I hereby authorize PATH Behavioral Health, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment, and treatment procedures. I further authorize PATH Behavioral Health, to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment for the purposes of verifying service delivery and reviewing client progress with funding sources.

Cancellation/ No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. Any appointment that is missed will be assessed a $50.00 no show fee (Applicable to Self-Pay, non-sliding scale, Clients only). The fee will not be assessed for people with Medicaid or Medicare. This charge is not covered by insurance and will be the sole responsibility of the client/guarantor. I understand if l no show for two consecutive appointments, no show for three appointments or cancel

for a total of four appointments, I may be discharged from care. PATH Behavioral Health will notify you in writing, via certified mail, if you are discharged from care.

Laboratory Services Policy

Generally, most laboratory specimens are sent to an outside laboratory or a specialty laboratory at your physician' s discretion. A copy of your information and insurance card is also sent. The laboratory will bill your insurance (if applicable) and notify you of your responsibility. You are responsible for notifying our staff at the time of your visit if your insurance company requires that your lab work be processed at a specific laboratory. Unless an alternate laboratory is indicated below, you agree to receive laboratory services as noted above.

Required Laboratory: _____

By signing this form, I agree to the following:

- The terms of the Acknowledgement of Patient Financial Responsibility
- The Co-Pay / Co-Insurance Policy
- Consent for Treatment and Authorization to Release Information
- Cancellation/ No Show Policy
- Laboratory Services Policy

Client Signature _____

Date_____

Guarantor Signature _____

Date _____
(If guarantor is not the primary client)

PATH
Behavioral Healthcare

AUTHORIZATION TO USE AND RELEASE PROTECTED HEALTH INFORMATION

Authorization to Bill

Signing this form will not increase patient financial responsibility; however, without your signature your insurance may not pay PATH Behavioral Healthcare, LLC for the services provided. This will leave the full billed charges as patient financial responsibility. Please provide copy of the insurance card to accompany this Assignment of Benefits.

Patient Name: _____

Policyholder/Insured: _____

Insurance:_____

Policy#:_____

Assignment of Insurance Benefits; Financial Responsibility: PATH Behavioral Healthcare, LLC will work for and with you in an effort to obtain proper reimbursement from your insurance plan. An assignment of benefits will assist PATH Behavioral Healthcare, LLC in working with your insurance plan.

I assign all applicable health insurance benefits to which I and/or my dependents are entitled to PATH Behavioral Healthcare, LLC. I certify that the health insurance information I have provided is accurate as of the date set forth below and that I am responsible for keeping it updated. I will use my best efforts to assist with submitting insurance claims. I authorize PATH Behavioral Healthcare, LLC to submit claims, on my and/or my dependent' s behalf, for payment to Medicare, Medicaid, or any other payer for services provided to me or my dependent. I also instruct my benefit plan (or its administrator) to pay PATH Behavioral Healthcare, LLC directly for the serv ices rendered to me or my dependent. To the extent that my current policy prohibits direct payment to PATH Behavioral Healthcare, LLC, I instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and PATH Behavioral Healthcare, LLC upon request. Upon proof of such nonassignment, I instruct my benefit plan (or its administrator) to make the check to me and mail it directly to PATH Behavioral Healthcare, LLC.

I assign the right to appeal payment denial or other adverse decisions made by my benefit plan (or its administrator), as well as the right to file a complaint or grievance, bring suit, or pursue arbitration, to PATH Behavioral Healthcare, LLC on my behalf. I understand that I am financially responsible for the billed charges for the services provided to patient by PATH Behavioral, LLC, regardless of my insurance coverage, and in some cases may be responsible for an amount in addition to that which is paid by my insurance, such as co-pay, co-insurance, deductible, and any remaining balance. I agree to immediately remit to PATH Behavioral Healthcare, LLC any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to PATH Behavioral Healthcare, LLC, LLC.

Authorization to Release Information: PATH Behavioral Healthcare, LLC may need to obtain information from other sources in order to receive appropriate reimbursement from all available insurance sources.

I authorize and direct any holder of medical information or documentation to include city, county, and state accident reports about me or my dependent to release such information to PATH Behavioral Healthcare, LLC, LLC, its billing agents, CMS, its carriers and agents and/or any other payers or insurers as may be appropriate to determine any benefits payable for these or any other medical services provided to me or my dependent by PATH Behavioral Healthcare, LLC, LLC.

Patient Signature: _ **Date:** _ _ _ _ _ _ _ _ _ _ _ _

Representative Signature: _ **Date:** _ _ _ _ _ _ _ _ _ _ _ _

(A representative is considered to be someone other than the patient who is responsible for the patient 's medical and/ or financial affairs.)

A copy of this form is valid as an original

PATH Behavioral Healthcare

AUTHORIZATION TO USE AND RELEASE PROTECTED HEALTH INFORMATION

This form authorizes PATH Behavioral Health to use and/or disclose protected health information in the manner described below. This is voluntary. Refusal to sign this form in no way impacts your ability to receive services provided by PATH Behavioral Healthcare. Each section of the form must be completed in its entirety or is considered invalid.

Client Information

I hereby authorize PATH BEHAVIORAL HEALTH to use and share protected health information about:	
Client Name:	Date of Birth:
Name of Parent/Guardian:	Relationship:

Information Released To (Note: Multiple people may be listed if within the same organization)

Name:	Organization (if applicable):
Address:	City/State/Zip Code:
Contact Number AND/OR Email Address:	Information can be: ☐ Fax ☐ Email ☐ Mail ☐ Picked Up ☐ Verbal

Information To Be Released and Purpose

Information Type:	Information Requested:	Purpose of Release:
☐ Identiying Information	☐ Educational Information	☐ Ongoing service Coordination
☐ Alcohol & Drug Treament Information (See 42 CFR)	☐ Assessment	☐ Referral
☐ Mental Health Tratment Information	☐ Treatment Plan	☐ Legal/Attorney Request
☐ Psychiatric Information	☐ Discharge Summary	☐ Other:_____
☐ Medical/Physical Health Information		

Expiration of the Release

This authorization may be revoked at any time by contacting the PATH Behavioral Health Privacy Officer or by contacting your service provider directly. This will not apply to information released prior to the receipt of the request for revocation. PATH Behavioral Health cannot release information provided by a third party. Refer to the agency Notice of Privacy Practice s for

additional information. This release will be reviewed and updated every 180 days. Upon discharge this release will be void.

Unless otherwise revoked, this release will expire in 180 days from the date it is signed, OR sooner, if specified, on (enter date if desired).

Situations that Do Not Require a Signed Release

Your records or information regarding you and /or family may not be released to any other individual or agency without your written consent. Certain information, however, may be released without your authorization under the following legal circumstances:

1. The receipt of a legitimate subpoena or court order.
2. In the event of a medical emergency.
3. The receipt of information that suggests that child/elder abuse or neglect has occurred.
4. If the worker believes that a member of the family is a danger to himself / herself or is a danger to others.
5. Other circumstances as required/permitted by law.

Client/Guardian AUTHORIZATION

I, the undersigned, hereby authorize PATH Behavioral Health to use and/or disclose information from my (or give relationship)_____ medical record as specified above. This authorization includes use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS related conditions, any drug and alcoholabuse, drug related conditions, alcoholism and/or psychiatric/psychological conditions to the above-mentioned entity(ies). I understand that I may inspect and have a copy of the health information described in this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plancovered by federal privacy regulations, the information may be re-disclosed and no longer protected by those regulations. I affirm that everything in this form has been explained and I believe I have a clear understanding of what myauthorization means. I understand that I may receive a copy of this completed form upon request.

Signature of Guardian (if Client under 18):	Date:
Signature of Client (required for AoD regardless of age):	Date:

PATH Behavioral Health WITNESS

I, a PATH Behavioral Health employee, have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person isnot fully competent to give informed and willing consent.

Signature of PATH Staff:	Date:

PATH Behavioral Healthcare

AUTHORIZATION TO USE AND RELEASE PROTECTED HEALTH INFORMATION

42 CFR: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless the further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CRF Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Situations that Do Not Require a Signed Release

Your records or information regarding you and /or family may not be released to any other individual or agency without your written consent. Certain in format ion, however, may be released without your authorization under the following legal circumstances:

1. The receipt of a legitimate subpoena or court order.
2. In the event of a medical emergency.
3. The receipt of information that suggests that child/elder abuse or neglect has occurred.
4. If the worker believes that a member of the fam il y is a danger to himself / herself or is a danger to others.

Other circumstances as required /permitted by law.

Client/Guardian AUTHORIZATION

I, the undersigned, hereby authorize PATH Behavioral Health to use and/or disclose information from my (or give relationship) _____medical record as specified above. This authorization includes use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS related conditions, any drug and alcoholabuse, drug related conditions, alcoholism and/or psychiatric/psychological conditions to the above-mentionedentity(ies).

I understand that I may inspect and have a copy of the health information described in this authorization.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by those regulations.

I affirm that everything in this form has been explained and I believe I have a clear understanding of what my authorization means. I understand that I may receive a copy of this completed form upon request.

Signature of Guardian (if Client under 18):	Date:
Signature of Client (required for AoD regardless of age):	Date:

PATH Behavioral Health WITNESS

I, a PATH Behavioral Health employee, have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person isnot fully competent to give informed and willing consent.

Signature of PATH Staff:	Date:

42 CFR: This information has been disclosed to you from records protected by Federal confidentiality rules {42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless the further disclosure is expressly permitted by the written consent ofthe person to whom it pertains or as otherwise permitted by 42CRF Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

1. The right to be treated with consideration and respect for personal dignity, autonomy and privacy;
2. The right to reasonable protection from physical, sexual or emotional abuse, neglect, humiliation, and inhumane treatment;
3. The right to receive services in the least restrictive, feasible environment;
4. The right to participate in any appropriate and available service that is consistent with an individual service plan (ISP), regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person's participation;
5. The right to give informed consent to or to refuse any service, treatment or therapy, including medication absent an emergency;
6. The right to participate in the development, review and revision of one's own individualized treatment plan and receive a copy of it;
7. The right to freedom from unnecessary or excessive medication, and to be free from restraint or seclusion unless there is immediate risk of physical harm to self or others;
8. The right to be informed and the right to refuse any unusual or hazardous treatment procedures;
9. The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio and visual technology. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms or sleeping areas;
10. The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations;
11. The right to have access to one's own client record unless access to certain information is restricted for clear treatment reasons. If access is restricted, the treatment plan shall include the reason for the restriction, a goal to remove the restriction, and the treatment being offered to remove the restriction;
12. The right to be informed a reasonable amount of time in advance of the reason for terminating participation in a service, and to be provided a referral, unless the service is unavailable or not necessary;
13. The right to be informed of the reason for denial of a service;
14. The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;
15. The right to know the cost of services;
16. The right to be verbally informed of all client rights, and to receive a written copy upon request;
17. The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations;
18. The right to file a grievance;
19. The right to have oral and written instructions concerning the procedure for filing a grievance, and to assistance in filing a grievance if requested;
20. The right to be informed of one's own condition; and,
21. The right to consult with an independent treatment specialist or legal counsel at one's own expense.

CLIENT GRIEVANCE PROCEDURE:

1. Consumer completes Grievance form provided by employee or through PATHIHC.COM and submits to the Operations Team. The Operations Team has 10 business days to investigate and respond in writing.
2. The Operations Team will attempt to resolve the issue. If The Operations Team resolution does not satisfactorily resolve the issue, the decision can be appealed in writing to the Clinical/Regional Director. The consumer is responsible for ensuring that the appeal is received by the Clinical/Regional Director within 10 business days of the Operations Team response. The Clinical/Regional Director is to receive a copy of the original grievance form completed and signed by the person served. The Clinical/Regional Director has 10 business days to respond in writing.
3. If the person served is dissatisfied the Clinical/Regional Director's decision a final appeal may be made to the CEO by submitting the grievance to the CEO. The Committee will hear the issue at the next regularly scheduled meeting.
    - A person served filing a grievance against the Clinical/Regional Director may appeal to The Operations Team. The

timeframes in Step One will apply.

- The person served has the right to contact respective licensing boards, and CARF at (888) 281-6531.
- Final decisions on grievances are not precedent setting or binding on future grievances unless they are officially stated as Company policy.
- The agency will not allow any retaliation against any person who files a grievance.
- An annual summary of grievances will be submitted by the Management Team to the CEO for determination of:
- trends, areas needing performance improvement, and actions to be taken.

I, the undersigned, hereby confirm that I have carefully reviewed and comprehended Path Behavioral Healthcare's policy concerning my rights and the grievance procedure. I am fully aware that the employees of Path Behavioral Healthcare are obligated to honor and uphold my rights diligently. Additionally, I am aware that I retain the right to request a copy of my rights and the Path Behavioral Healthcare grievance procedure at any given time.

_____ _____

Signature **Date**

PATH
Behavioral Healthcare

CONSENT FOR TREATMENT

CLIENT NAME: _____

CLIENT DOB: _____

Description of Treatment Services and Expectations
I understand that I and/or my family will be receiving services as a client of Path Behavioral Healthcare. I understand that the time will be set between the staff and me. As a Path Behavioral Healthcare Client. I commit to improving my behavior and to developing a responsible, healthy lifestyle. I agree, at a minimum, to the following:

- Giving the program a chance to help me
- Actively participating in treatment
- Following through on Referrals
- Working on my educational/vocational plan
- Maintaining confidentiality of other clients
- Authorization for staff to transport myself or my family
- Recreational outings
- Vocational outings
- Following all program guidelines
- Maintaining recommended contact with treatment team
- Developing a crisis/safety plan
- Treating all staff and clients with respect
- Refraining from all aggressive, harmful and illegal behaviors
- Following all probation guidelines (if applicable)
- Other activities as indicated in my Childs treatment plan

PATH Behavioral Health's services include assessment; mental health and alcohol and drug services including therapy and/or case management, nursing, medication management services: assistance with treatment goals; development of daily living and life skills; collaboration with referral sources and other service providers and referrals to community supports. These services are designed to help me achieve my goals and develop a healthy, responsible, lifestyle.

Benefits or Program Participation: may include improved functioning in home, school, and community as well as therapy for at risk youth, prevention of the disruption of placement, while promoting the least restrictive level of care., as well as your who are transitioning form a residential setting or foster care to a natural family. Path Behavioral Healthcare serves are tailored to meet the needs of individuals and families
It has been explained to me that I am a full partner i n the development of mine or my family's Individual Service Plan and that I will be participating in all team meetings. I understand that I can maintain my status in the program by participating in the offered services.

Drug and Alcohol Services

42 CFR is a federal law that describes special confidentially rules related to drug and alcohol treatment services. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless the further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CRF Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Signature (if age 14 years or above):	Date:
Please Print Name of Client or Guardian	
Parent/Guardian Signature (if applicable):	Date:
PATH Staff Signature:	Date:

PATH
Behavioral Healthcare

E-PRESCRIBING PBM CONSENT FORM

Whenever possible, path behavioral healthcare sends your prescription(s) to your pharmacy through a process known as e-prescribing. E-prescribingis defined as a physician's ability to electronically send an accurate, error-free and understandable prescription directly to the pharmacy.
E-prescribe is an important element in improving the quality of patient careand is required by many insurance companies.

Benefits data is maintained for health insurance providers by organizations known as pharmacy benefit managers (pbm). Pbm's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain a list of drugs covered by your drug benefit plan.

E-prescribe programs must include:

- Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan
- Medication history transactions - provides the physician with information about medications the patient is already taking prescribedby another provider to minimize the number of adverse drug events

BY SIGNING THIS CONSENT, YOU AGREE THAT PATH BEHAVIORAL HEALTHCARE CANREQUEST AND USE YOUR PRESCRIPTION MEDICATION HISTORY FROM THIRD-PARTY PHARMACY BENEFIT MANAGEMENT FOR PRESCRIBING AND TREATMENT PURPOSES.

_____ _____

Patient Name (PRINTED) **Date of Birth**

_____ _____

Signature of patient (or responsible party) **Relationship to patient**

I DO NOT CONSENT

_____ _____

Signature of patient (or responsible party)

PATH
Behavioral Healthcare

CLIENT HANDBOOK & HIPPA ACKNOWLEDGEMENT

I, _____, hereby acknowledge that I was given a copy of the Client Handbook and Notice of Privacy Policy issued by PATH Behavioral Health on the date indicated below.

_____ _____

Client/Guardian Signature **Date**

_____

Client Name (If other than above)

_____

***Relationship to Client:**

*If parent/guardian (or other personal representative) of the Client, please indicate type of relationship.

_____ _____

Witness Signature **Date**

_____ _____

PATH Staff Signature **Date**

PATH Behavioral Healthcare

PATH INTAKE CHECKLIST

Client Name:

Information Reviewed	
All Services (check all that apply)	
☐	Agency Mission
☐	Clients Rights and Responsibilities w/ Grievance and appeal procedures
☐	Consent for Treatment including Client Expectations
☐	HIPAA Notice with Signed Acknowledgement Form
☐	Fee Agreement
☐	Authorization to Use and Release Information (ROI)
☐	Transition/Discharge Criteria
☐	PATH Behavioral Healthcare Code of Ethics
☐	Policy on smoking, illicit or licit drugs, contraband, and weapons
☐	Identification of emergency exits, fire suppression, first aid kits
☐	Hours of operation of Service and After hours/Emergency Access
☐	Identification of the purpose and process of assessment and ISP development and staff responsible for coordination of services
Additional Service Specific Items (check all that apply)	
☐	
☐	

To be completed within 30 days of intake date.

Client Signature:	Date:
Parent/Guardian Signature (if client is under 18):	Date:
Staff Signature:	Date:

PATH Behavioral Healthcare

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Client Name:_____ **Client DOB:**_____

1. You have the right to receive a paper copy of the Notice and/or an electronic copy by email upon request. PATH Behavioral Healthcare has the right to review this Notice, and if revisions are made to this Notice, you have the right to receive the revised copy.
2. You have the right to file a complaint with PATH, if you think we may have violated your privacy rights, or if you disagree with a decision, we made about access to your Protected Health Information (PHI). You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington D.C., 20201 or call 1-877-696-6775. There will not be any penalties against you if you make a complaint.
3. PATH Behavioral Healthcare is required to maintain the privacy of the information in your file, and to abide by the terms of this notice.
4. Your Protected Health Information (PHI) refers to individually identifiable information relating to the past, present, or future physical or mental health or condition of you the client, provision of health care to you, or the past, present, or future paymentfor health care provided to you.
5. PATH Behavioral Healthcare maintains a limited right to use and/or disclose your PHI for purposes of treatment, payment, and health care operations as follows:

For Treatment

We may use medical information about you to provide you with behavioral health and medical treatment or services. We may disclose medical information about you to doctors, nurses, counselors, healthcare professionals in training, or other agency personnel who are involved in taking care of you through the agency. For example, a medical diagnosis may be shared with a specialist to help in your treatment process. Different departments of the agency may also share medical information about you to coordinate the different things you need, such as prescriptions, counseling, and residential support.

For Payment

We may use and disclose medical information about you so that the treatment and services you receive at the agency may be billed to and payment may be collected from you, an insurance company or a third party. For example, we need to give the Ohio Medicaid/ADAM HS Board and/or the State Departments information about counseling you received at the agency, so the Board will pay us for the services.

For Healthcare Operations

We may use and disclose medical information about you for agency operations. These uses and disclosures are necessary torun the agency and make sure that all of our clients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical

information about many agency clients to decide what additional services the agency should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health professionals in training, and other agency personnel for review and learning purposes. We may also combine the medical information we have with medical information from other agencies to compare how we are doing andsee where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study healthcare and healthcare delivery without learning who the specific clients are.

6. PATH Behavioral Healthcare maintains a right or is required by law to use and/or disclose your PHI in certain circumstances without your authorization. Refer to PATH Behavioral Healthcare HIPAA Policies and Procedures manual for specific explanations regarding these cases. The following circumstances do not require your authorization: to employers (for medical surveillance activities); concerning victims of abuse, neglect, or domestic violence; to health oversight agencies; for judicial/administrative proceedings; for law enforcement purposes; for approved research; to correctional institutes; to avert a serious threat to health or safety; for worker's compensation purposes; and relating to decedents.
7. You have the right to revoke your authorization at any time to stop future uses and/or disclosures expect to the extent that PATH Behavioral Healthcare has already undertaken an action in reliance upon your authorization.
8. PATH Behavioral Healthcare may send appointment reminders and other similar materials to your home unless you provide us with alternative instructions.
9. PATH Behavioral Healthcare may contact you about treatment alternatives or other health related benefits and services.
10. You have the right to request the receipt of confidential communications by alternative means or at alternative locations as long as it is reasonably easy for PATH Behavioral Healthcare to do so.
11. If PATH Behavioral Healthcare informs you about the disclosure in advance and you do not object, PATH Behavioral Healthcare may share with your family, friends, or others involved in your care, information directly related to their involvement in your care, or payment for your care. PATH Behavioral Healthcare may also share PHI with these people to notify them about your location, general condition, or death.
12. You have the right to request restrictions on uses and disclosures of information in your file. PATH Behavioral Healthcare is not required to agree to requested restrictions.
13. You have the right to receive confidential communications of PHI, and you also have the right to inspect, copy, and amend yourPHI as permitted under the regulations of HIPAA.
14 . You have the right to receive a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure: for treatment, payment, and operations; to you, your family, or the facility Director; or pursuant to your written authorization. The list will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before April 14, 2003. PATH Behavioral d Healthcare will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as 7 years.
15. You may complain to PATH Behavioral Healthcare and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

SUBSTANCE ABUSE ONLY

1. The Confidentiality of Protected Health Information (PHI) related to alcohol and/or drug abuse is protected by Federal

law, 42 CFR 2 and regulations. Violations of the applicable Federal law and regulations are a crime and may be reported to appropriateauthorities.

2. We may not disclose any information about you unless you authorize the disclosure in writing, except as specified below.
3. We may disclose information about you if a court orders the disclosure.
4. We may disclose information about you in a medical emergency, to permit you to receive needed treatment.
5. We may disclose information about you for purposes of program evaluation, audits, or research.
6. We may disclose information if you commit a crime on our premises or against any person employed with us, or if you threaten to commit such a crime.
7. We are required to disclose information about you if we suspect child abuse or neglect.
8. Except as stated in this notice, you have the same rights and protections with respect to your health information as described inour general Notice of Privacy Practices.

I have read, understand, and have received a copy of the Notice of Privacy Practices Form.

_____ _____

Client, Parent/Guardian Signature (if client underage of 18) **Date**

_____ _____

PATH Staff Signature **Date**

PATH
Behavioral Healthcare

TELEHEALTH INFORMED CONSENT FORM

Client: - Effective Date: - - - - - - - - - - - - - - -

Client Date of Birth: - - - - - - - - - - - Expiration Date: _ _ _ _ _ _ _ _ _ _

I, _____ consent to engage in telehealth with PAH Behavioral Health as part f the therapy process and my treatment goals. I understand that telehealth behavioral health services may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio, video, telephone, and/or other audio/video communications.

I understand I have the following rights with respect to telehealth:

1. I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2. The laws that protect the confidentiality of my personal information also apply to telehealth. I understand that the information released by me during my sessions is generally confidential. There are exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the sharing of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

3. I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Path Behavioral Health that : the transmission of my personal information could be disruptedor distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

   In addition, I understand that telehealth-based services and care may not be as complete as in-person services. I understand that if my therapist believes I would be better served by other interventions I will be referred to behavioral health providers who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental or behavioral health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to worsen.

4. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed any concerns with my therapist, and all my questions regarding the above matters have been answered to my approval. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with these communication systems.

   Signing this form shows an awarenessof these issues and a decision by me to use these systems for telehealth services. I will not hold Path Behavioral Healthcare or itsstaff liable for issues with this system beyond their control.

5. I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed any concerns with my therapist, and all my questions regarding the above matters have been answered to my approval.

6. By signing this consent, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. I understand I have the right to

access my personal information and copies of case notes . I have read and understand the information provided above. I have discussed any concerns with my therapist, and all my questions regarding the above matters have been answered to my approval. By signing this document, I understand that emergency situations may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threating or emergency, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies or the National Suicide Lifeline at 1-800-273-8255.

Client, Parent/Guardian Signature (if client under age of 18) **Date**

PATH Staff Signature **Date**

PATH Behavioral Healthcare

SUMMARY OF CLIENT FINACIAL RESPONSIBILITY

Client Name: _____ DOB: _____

Guarantor Name: _____ DOB:_____

Self-Pay Agreement/Waiver

- ☐ I acknowledge that I will be solely financially responsible for services rendered here at PATH Behavioral Health. I agree to pre-pay PATH Behavioral Health, the full and entire amount of treatment prior to each service given to me or to the above-named patient at each visit.
- ☐ I have Medicaid, however, should my benefits lapse or be terminated, I understand that I will automatically be moved to Self-Pay. I agree to communicate with PATH staff if this occurs, especially if I am reapplying for Medicaid.
- ☐ I have health insurance; however, I chose not to utilize my health care benefits. I understand that I will automatically be Self-Pay and agree to pay the rates on this form for each visit.
- ☐ I understand any appointment that is missed will be assessed a $50.00 no show fee.

Client/Guarantor Signature _____ Date _____

PATH Behavioral Health appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our stated fees. This form provides information about our fee schedule. You are responsible for payment of your bill prior to each service and a breakdown of that responsibility can be found below. We do utilize Medicaid's rates for the self-pay rates. We do not mark up any charges. You will only be billed for the time you select and prepay for. We will give you a paid receipt so you can submit to your commercial insurance company, if applicable. Any questions, please contact the billing department at: billing@pathihc.com.

PATH Model for Client Fees

PATH Behavioral Health subscribes to a model of therapy that recommends clients participate in the least amount of sessions needed to stabilize their current symptomology, identify the core issues that contributed to their initial or ongoing distress, identify primary client strengths and resources that they can utilize to move forward in a positive manner, formulate an individualized plan for each client, and assist clients in developing the necessary skills to address these issues independently and without ongoing clinical intervention.

Summary of Ongoing Charges

I have read the above policy regarding my financial responsibility to PATH Behavioral Healthcare for providing services to me or the above-named client. I acknowledge that this only represents currently planned services and that additional services may be offered based upon clinical recommendation. PATH Behavioral Healthcare will notify me and gain approval prior to offering any additional services. I certify that the information is, to the best of my knowledge, true and accurate.

Client/Guarantor Signature _____ Date _____

Service Fees

Code	Appointment Type	2024 Self Pay Rates:	Max Time
Initial Services			
90791	Intake Diagnostic Eval	$150.00	90 min
99204	E/M New Patient	$210.00	60 min

PATH Behavioral Healthcare

SUMMARY OF CLIENT FINACIAL RESPONSIBILITY

Ongoing Services			
90832	Ind Psy/ISP Update (30 Min)	$75.00	30 min
90837	Ind Psy/ISP Update (60 Min)	$150.00	60 min
90847	Family Psych (Family Therapy with or without client present)	$125.00	50 min
90853	Group Psychotherapy	$50.00	90 min
H0036	Case Management (30 Min)	$50.00	30 min
H0036	Case Management (60 Min)	$100.00	60 min
99214	E/M Established Patient (30 Min)	$150.00	30 min
99215	E/M Established Patient (45 Min)	$200.00	45 min
H2019	Nursing (30 Min)	$80.00	30 min
H2019	Nursing (40 Min)	$110.00	40 min