Aultman Medical Group
Behavioral Health Center
Client Information and Consent

Client Name:_____ Date of Birth:_____

Aultman Medical Group's Behavioral Health Center provides mental health care services to individuals and their families through trained psychiatrists, clinical nurse specialists and counselors. To receive care and treatment at the Behavioral Health Center, I understand that I must read the information and follow the guidelines in this Client Information and Consent form.

- *Appointments/Cancellations*

Appointments can be made by calling (330) 493-9607, Monday through Friday, 8:00 a.m. to 4:00 p.m. If you need to cancel or reschedule your appointment, please call at least 24 hours in advance. Three (3) missed appointments without proper notice may lead to your discharge from the Behavioral Health Center.

- *Therapy and Medication Management*

If therapy or medication management sessions are part of your treatment plan, the number of therapy sessions that you need to attend will be discussed with you by your provider. Therapy sessions are 45 minutes in length and the time for medication management sessions will vary.

- *Confidentiality*

All services provided to you by the Behavioral Health Center, including scheduling of or attendance at appointments, your therapy and/or medication management sessions, counseling and your treatment records are confidential. The Behavioral Health Center staff works as a team, and your provider may consult with other staff members regarding your treatment plan. All such consultations are confidential. The Behavioral Health Center will not release your treatment records or information to any person without your written authorization unless required by law. In such circumstance, the Behavioral Health Center will disclose your treatment records and information only as necessary to comply with the law. For example:

- If there is evidence of an explicit threat to you and/or made by you about imminent and serious physical harm to, or causing the death of one or more potential victims, your provider may be required to report this information to the authorities.

- If your provider learns of, or reasonably suspects, the abuse or neglect of any child or elderly person, your provider must report this information to the authorities.

- If your provider is ordered by the court to disclose your treatment information.

- The Behavioral Health Center will disclose treatment information to your insurance to obtain payment for services provided to you.

The Behavioral Health Center's Notice of Privacy Practices provides more information on how the Behavioral Health Center uses and discloses your treatment and health information. You may request a copy of the Notice of Privacy Practices from our office. If you have questions about confidentiality, please discuss with your provider.

After Hours Emergencies

If you need assistance after our office closes or on the weekends, contact the Crisis Intervention & Recovery Center any time at (330) 452-6000 or (800) 956-6630. If you have an emergency that requires immediate attention, you can go to the nearest hospital emergency department or call 911.

Contact Information

- Please indicate how you would like to be contacted by the Behavioral Health Center and your provider:

  □ Telephone (_____) _____

  □ E-mail _____

- Your mailing address: _____
  _____

- ***Emergency Contact Information:***

  Name_____ Telephone _____

- Your primary doctor:

  Name_____ Telephone _____

  □ By checking this box, I authorize the Behavioral Health Center to send a copy of my initial assessment and evaluation to the above-named doctor.

You are responsible to timely notify the Behavioral Health Center of any changes to your contact information.

Payment for Services

The Behavioral Health Center will submit a claim for the services you receive to your insurance plan. Any balance remaining after the Behavioral Health Center receives an insurance payment is your responsibility. You must pay any balance in full upon receipt of a billing statement. As a Client of the Behavioral Health Center, you will –

- Provide us with your current insurance information
- Inform our office when your insurance coverage changes or ends
- Pay co-payments and deductibles at the time of service
- Pay your outstanding balance in full when you receive a billing statement
- Work with your employer and insurance company if there is a problem with a claim submitted to your insurance plan.

Consent to Treatment and Authorization for Payment

I have carefully read this Client Information and Consent form, or had this form read to me. I understand the information contained in this form. I had the opportunity to ask questions.

By signing below, I acknowledge and agree that:

- I voluntarily consent to receive treatment and services at the Behavioral Health Center. I give my permission to the Behavioral Health Center, and to my provider(s), to administer any therapy, service or treatment deemed necessary or advisable. I also specifically consent to medical procedures and tests determined necessary to assist in my diagnosis and treatment. I understand that I may stop my care, treatment or services at any time.

- I understand my responsibilities as a Client of the Behavioral Health Center.

- I authorize Aultman Medical Group ("AMG") to bill my insurance, including Medicaid and/or Medicare, for the services that the Behavioral Health Center provides to me and I hereby assign the payment of any medical benefits under such insurance to AMG. I further authorize AMG to release my medical or other information as necessary to obtain payment for services provided to me by AMG at the Behavioral Health Center. I understand that I am responsible for any and all payment obligations arising out of the care, treatment and services provided to me by AMG, including deductibles, co-payments and any other payment responsibility under my insurance policy or for any service that is not covered by my insurance. I understand that co-payments, deductibles and other payments may be due on the date of my appointment and that AMG will collect such payment before services are provided to me. I understand that I have a right to review AMG's Patient Account/Financial Policy and that I may direct questions about this policy to AMG's Patient Accounts Department. I recognize that AMG's policies may change from time to time, without notice to me.

Client Signature:_____ **Date:** _____

If you are signing on behalf of the Client, please print name and indicate your relationship (or legal authority) with/for the Client:

Name:_____ Relationship:_____

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