Patient Information/Consent Form

Welcome to Daily Behavioral Health. Please read, complete, and sign the following documents. We look forward to working with you, your child, and/or your family.

Patient Name:

Date of Birth: **Age:**

Patient School/Employer:

Parent/Guardian:

Phone: **Email:**

Additional Parent/Guardian:

Phone: **Email:**

Address of Primary Parent/Guardian:

People Living in Your Home (Name, age, relationship, and school/employer):

Describe any major medical/physical problems, previous diagnoses, and allergies:

List current medications (dosage and prescribing physician):

Presenting Problem:

Testing and/or Treatment Goals:

Insurance Information

Name of Insurance Carrier:

Relationship of Patient to Subscriber:

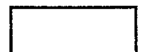
Member ID for Patient:

Fee Agreement

1. *Fees:* Our standard fee is currently $200 for an initial evaluation and $50 for each 15 minutes of service (e.g., $200 for a 60 minute session, $150 for a 45 minute session). Psychological testing, speech/language services, classes, workshops, and groups may involve additional or separate charges. Payment is due at the time of session, although other billing arrangements may be made on a case-by-case basis. Phone sessions are billed on a per-minute basis, starting for phone calls over 10 minutes in length. A sliding scale is available for psychological services, based on your personal circumstances. In cases of shared custody, or any situation where billing is split between more than one person, the individual who brings the patient in, is responsible for payment of co-pays, coinsurance and nonparticipating insurance balances at the time of service. We will not bill more than one household for the patient's service.

2. *Treatment Concerns:* All of our therapists at Daily Behavioral Health have a Masters Degree or a Doctoral Degree in psychology or a related field. Some service providers may be doctoral trainees. All psychological services are conducted or supervised by a licensed psychologist. While psychological treatment may vastly improve the quality of your life, it is also an expensive process. The duration of therapy is affected by the nature of your concerns and what your goals are. It is very important that you feel that you are benefiting from treatment. If at any time you feel that you are not getting what you want or need out of therapy, I urge you to discuss this with your therapist so that we can find a solution for your concerns. You also have the right to request a consultation with the supervisor if you have questions.

3. *Appointment Cancellations:* Fees are based on the time we commit to work with you in sessions. To keep client fees low, any scheduled session not cancelled 24 hours in advance will be charged the established fee of $75.



4. *Fee Agreement:* I agree that, in signing this Agreement, I have read and fully understand the terms contained herein. I am responsible for copays and any fees that are not covered by my insurance. My insurance is billed $200.00 for each initial evaluation appointment (may take two appointments), $250.00 for each 75 minute follow-up session, $200 for each 60 minute testing or therapy session, $150.00 for each 45 minute session, $100 for each 20-30 minute follow-up session, and $50.00 for each 15 minutes of service.

   Fees are due at the time of the schedule session, unless other arrangements are made in advance. This fee may be renegotiated in a new Fee Agreement from time to time as the financial situation of this business may change. In the unlikely event that check funds are dishonored, I give authorization for the funds to be collected electronically for the face value of the check, plus a $25 (or legal limit) processing fee. I understand that Daily Behavioral Health requests that a credit card authorization form be kept on file in the event that I have an outstanding balance past 120 days and have not made any arrangements for payment. If my account becomes delinquent due to non-payment I agree that I am responsible for the cost of the services performed, any missed visits, interest of 1.5% per month, collection agency fees, court costs, and any other costs associated with the collection of my debt. I understand that my insurance company may pay all, some, or none of the amount due to Daily Behavioral Health, Inc. and I assume responsibility for any unpaid balances.

I give my permission for psychological evaluation, treatment, and/or testing of above patient at Daily Behavioral Health. I give permission for email and/or text of appointment reminders. I have read and understand the HIPAA Compliance Policy. I can request a copy of the HIPAA Compliance Policy at any time.

I authorize payment of medical benefits to the provider/Daily Behavioral Health for services provided. I authorize the release of any medical or other information necessary to process claims for service by the provider/provider organization above. I also request payment of government benefits to myself or to the party who accepts assignment.

Patient Name:

Patient/Guardian Signature: [ ] **Date:**

HIPAA NOTICE OF PRIVACY PRACTICES

I. 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.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice. Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to corresponding federal statutes of regulations**, such as the Privacy Rule that requires this Notice.
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by Child Abuse and Neglect Reporting laws.** For example, if I have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by Elder/Dependent Adult Abuse Reporting laws.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.

13. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
14. **For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.
15. **Appointment reminders and health related benefits or services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.
16. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
18. **If disclosure is otherwise specifically required by law.**

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by

them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before September 9, 2004. After September 9, 2004, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2004-2010) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and

Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact Dr. Cara Marker Daily at 14538 Grapeland Avenue, Cleveland, Ohio, 44111.

VII. EFFECTIVE DATE OF THIS NOIICE

This notice went into effect on September 9, 2004.

Daily Behavioral Health
Commonly Asked Questions About Comprehensive Evaluations

What does a comprehensive evaluation include?
We evaluate your child's strengths and weaknesses to determine their diagnosis and best treatment options. Depending upon the type of evaluation requested (e.g., Autism, ADHD, Learning Disabilities, Anxiety/Depression, Giftedness), your child's comprehensive evaluations may include:

- Cognitive Ability
- Academic Achievement
- Behavioral and Social-Emotional Functioning
- Adaptive Behavior Scales
- ADHD Rating and Assessment Scales
- Autism Rating and Assessment Scales
- Child Observations and Interviews
- Parent and Teacher Interviews
- Review of Previous Records

Who conducts the evaluation? All comprehensive diagnostic evaluations are conducted or supervised by a licensed psychologist.

How long will the evaluation take? Evaluations typically take approximately eight hours of testing (spread out over sessions of one to two hours each). After the testing is complete, it usually takes an additional four to eight weeks to talk with your child's teacher (if consent is given), interpret the results, and write the report.

Will my insurance company pay for the evaluation? Most insurance companies pay for the testing of comprehensive evaluations, although it is important for you to contact your specific carrier to confirm how many hours they cover. When talking with your carrier, ask specifically about how many hours of the CPT Code 96101 (a specific testing code) they will cover. If they only allow for six hours, please request an additional two hours (which may or may not be used). In the rare case that the testing is longer than the amount of hours allowed by your insurance, then you will be liable for each additional hour of testing at $200.00 an hour. You will also be liable for all co-pays, which may occur for each hour of testing. Some hours of testing are billed without the patient present, which is to cover our time spent scoring and interpreting testing results and writing the report, which is typically six to ten pages long.

How and when will I receive the results? After approximately four to eight weeks after testing, your doctor will set up a 45 minute feedback session to explain the results and recommendations in your child's report.

COVID-19 GUIDELINES

Please text or call 216-252-1399 with the patient's name to let our office staff know you have arrived.

Wait in your car until you receive a confirmation text to come into the building.

You will receive a brief health screening when entering the building. If you are able, please wear a face mask and wash your hands or use hand sanitizer upon entering the building. Remember to maintain at least six feet of physical distancing wherever possible.

Please reschedule your appointment if you have:

1. A fever with a temperature over 100.0° F or higher
2. Respiratory symptoms (cough or shortness of breath)
3. Traveled to a COVID-19 outbreak area in past 14 days
4. Been in contact with anyone suspected or diagnosed with COVID-19 in the last 14 days without a mask.

COVID-19 In Home Therapy Policy

If you are receiving home-based therapy, we ask that you provide daily communication with our staff to ensure that the following is conducted before our arrival:

1. Check temperatures of those in the house. If anyone has a fever of or over 100 degrees F, has respiratory symptoms (cough or shortness of breath), or been exposed to someone with suspected or diagnosed COVID-19 within the last 14 days without wearing a mask, please cancel your appointment.
2. Please disinfect/sanitize the therapy area and have the child wash or sanitize his or her hands upon our arrival.
3. For those able, wear a face mask in our presence.
4. Maintain six feet of physical distancing wherever possible.
5. Our providers will be wearing proper Personal Protective Equipment (PPE) upon entering your home. This includes a face mask or face shield and gloves.
6. Please provide our therapist with soap and paper towel or sanitizer to allow us to properly wash our hands when necessary.

Telehealth Informed Consent

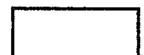
Given the current coronavirus outbreak, Daily Behavioral Health (DBH) is prepared to offer telehealth as an option, only if necessary, for our patients. Telehealth therapy with DBH providers will occur primarily through telephone conversations and/or secured video-based services and may involve email exchanges.

My signature below signifies my consent to engage in telehealth therapy with a service provider at DBH. Service providers may include psychologists, counselors, social workers, Board Certified Behavior Analysts (BCBA), and Speech Language Pathologists (SLP).

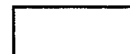
- Telehealth therapy with psychologists, counselors, or social workers includes the practice of education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making. Telehealth therapy may include behavioral health care delivery, diagnosis, consultation, and psychotherapeutic treatment.
- Telehealth therapy with BCBAs to provide Applied Behavioral Analysis (ABA) services includes behavioral consultation and remote supervision of behavior technicians.
- Telehealth therapy with SLPs includes the assessment, treatment, and consultation of a wide range of speech and language disorders.

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

1. I have the right to withhold or withdraw consent at any time. If consent is withheld or withdrawn, I may have the option to speak with the service provider to request a referral to another community service provider.
2. I understand that telehealth may not be as complete as face-to-face services. The use of telehealth therapy is subject to the discretion of DBH service providers, is temporary in nature, and based upon the assessment of a client's clinical needs. You and your service provider will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology. Face-to-face behavioral health sessions will resume after the necessity for the temporary telehealth sessions has passed.
3. Receiving telehealth therapy may be contraindicated with:
    - recent suicide attempt(s), psychiatric hospitalization, or psychotic processing (last 3 years)
    - moderate to severe major depression or bipolar disorder symptoms
    - moderate to severe substance abuse or dependence symptoms
    - severe eating disorders
    - a clinical presentation with severe physical symptoms that requires medical attention
    - repeated "acute" crises (e.g., occurring once a month or more frequently)
4. Telehealth services delivered by my therapist are required by law to take place within the state of Ohio. If I am physically located outside of the state of Ohio, I will immediately notify my therapist.
5. Telehealth therapy appointments occur at the time agreed upon between you and your provider. If you miss your scheduled appointment, you must contact your service provider.



6. It is my responsibility to confirm coverage of telehealth from my insurance and pay for any services not reimbursed by my insurance. I understand I may also be charged for missed appointments.
7. The laws that protect the confidentiality of your personal information and clinical treatment record also apply to telehealth therapy. As such, I understand that the information disclosed by me during the course of telehealth sessions is generally confidential. However, there are exceptions to confidentiality, including:
   - The client is in imminent danger of harm to self or others and it is necessary to ensure the client's and/or other's safety.
   - The provider has reason to suspect the presence of abuse or neglect of a child, an elderly person, or dependent adult; and must make a mandatory report to Child and Family Services.
   - A DBH service provider is presented with a valid court order.
   - The client is a minor and information is requested by their parent or guardian.
8. I agree not to record telehealth sessions and must disclose to my service provider if anyone else is participating in or listening to the conversation. It is my responsibility to maintain privacy on the client-end of communication by ensuring the privacy of my location.
9. I understand that my telehealth provider may not be available for contact between scheduled sessions.
10. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that:
    a. the transmission of my personal information could be disrupted or distorted by technical failures;
    b. the transmission of my personal information could be interrupted by unauthorized persons; and/or
    c. the electronic storage of my personal information could be accessed by unauthorized persons.
11. I understand that I may benefit from telehealth therapy, but results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of therapy, and despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.
12. I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based telehealth therapy services.
    a. I acknowledge that if I am in crisis or in an emergency I should immediately call 911 or seek help from a hospital or crisis orientation health care facility in my immediate area.
        i. If understand that emergency situations include if I have thoughts about hurting or killing either myself or another person, if I have hallucinations, if I am in a life threatening or emergency situation of any kind, having uncontrollable emotional reactions, or if I am dysfunctional due to abusing alcohol or drugs



  b. I acknowledge that I have been told if I feel suicidal, I am to call the National Suicide Hotline (1-800-784-2433) or 911, or go to the closet psychiatric emergency room (closest to DBH is Fairview Hospital for children and adolescents, Lutheran Hospital for adults).

13. I agree to provide a back-up phone number in case we are disconnected during our telehealth session.
14. The laws and professional standards that apply to in-person psychological, speech-language, and BCBA services also apply to telehealth services. My provider will continue to take notes and documentation of telehealth sessions similar to in-person sessions. I understand that this document does not replace other agreements, contracts, or documentation of informed consent.

I have read and understand the information provided above, including the COVID-19 Guidelines and Telehealth Consent Form. By electronically signing this document I agree to follow these guidelines and expectations for telehealth services through Daily Behavioral Health.

Patient Name:

Patient/Guardian Signature: [ ] **Date:**