BHA

"A Non-Profit Health Care Foundation"

413 Bridge Street, Weissport, PA 18235

610-379-9304

bhaeducation.org
bhaservices.com

@BHAMentalHealthServices

**Outpatient Treatment Contract**

Please read carefully, initial on each page, sign and date on the last page. If you have any questions please ask.

**Counseling and Psychotherapy**

This document contains important information about professional services and business policies at Behavior Health Associates (BHA). Please read it carefully and ask about any questions and concerns you might have, so that we can discuss them at our meeting. Your counseling is voluntary and you may withdraw from counseling at any time.

Please ask any of our Mental Health Professionals (MHP) about their education and their professional training.

Counseling and psychotherapy is not easily described in general statements. Counseling, psychotherapy or talk therapy is a treatment for many mental complaints. It varies depending on the particular problems you bring forward. There are many different methods your MHP may use to deal with the problems that you hope to address. Counseling and psychotherapy is not like a medical doctor visit. Instead, it calls for an active effort on your part and some self reflection. Achieving your goals depends upon the nature and frequency of your complaints and motivation to apply what is learned outside of sessions. During your sessions, you may feel a range of feelings and sensations. Unpleasant sessions are usually short-lived. Counseling and psychotherapy often leads to clarifying personal goals in life, better relationships, improved realistic self esteem, self –acceptance , personal awareness, increased personal responsibility, solutions to specific problems and significant reductions in feelings of distress.

Our first few sessions will involve an assessment of your needs in order to form your treatment plan. By the end of the evaluation, your MHP will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with your therapy. Some clients need only a few counseling sessions to achieve these goals, while others may require months or years of counseling. If you have questions about any counseling methods, we should discuss them whenever they arise. If at any point in counseling you and your MHP believe that you are not making progress toward your treatment goals, possible referrals to other MHP's will be considered. If you feel that you and your MHP are not well matched to your needs, your MHP would be happy to provide you referrals to another MHP. As you meet your treatment goals, BHA recommends a final treatment session, in order to discuss maintaining your progress to your personal growth.

**Medication**

Sometimes, psychotherapy alone will suffice. Often times, however a combination of psychotherapy and medication is optimal. Medication may be indicated when your mental symptoms are not responsive to psychotherapy alone. If it is agreed that medications are indicated, a BHA Psychiatrist will discuss with you all of the medication options that are available to treat your current condition. The Psychiatrist will present information in language that you can understand. You will learn how the mediation works, its dosage, and frequency, its expected benefits, possible side effects, drug interactions, and any withdrawal effects you may experience if you stop taking the medication abruptly. By the end of the discussion, you will have all the information you need to make a rational decision as to which medication is right for you.

Not everyone is a good candidate for medication therapy. Such therapies require strict adherence to dosage, and frequency, close follow-up, and sometimes regular blood tests. Your ability to adhere to medication treatment will be taken into consideration in making the decision to start such therapy.

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**Medical Information and Physician Contact**
Please notify your Psychiatrist/ MHP as soon as possible if there is any changes in your medical condition or change of medication.

Physical and psychological symptoms often interact. BHA encourages you to seek medical consultation if warranted. In addition, medications may sometimes be helpful for psychological problems. When appropriate, your MHP will arrange for a referral for a psychiatric evaluation.

**Confidentiality**
Your MHP will keep confidential anything you say, with the following exceptions: a) you direct your MHP to tell someone else, b) Your MHP determines you are in imminent danger to yourself or others ( the MHP has a duty to warn), c) Your MHP is ordered by a court to disclose information (with a subpoena BHA will need a signed release and with a court order BHA will not need a release), d) you disclose knowledge of physical, neglect or sexual abuse to a minor, BHA assures that our services will be rendered in a professional manner, consistent with accepted ethical standards. You have the right to review your treatment records with your MHP.

If you are seeing a MHP for couples or family therapy, and you, your partner or another family member should happen to see one of our MHP in an individual session, information shared in that meeting may be shared in a couple or family session if your MHP believes it to be in the best interest of the work we are doing together. Your MHP will discuss this matter with you before sharing that information. If your therapeutic relationship involves more than one person (e.g. spouse, parent, partner) your MHP will not release any information to a third party (court, attorney, etc.) without the signed permission of all parties involved in our sessions unless it falls under our mandate to report (as indicated in the above paragraph).

**Phone and emergency policy**
If you need to contact your MHP by phone, do not hesitate to call during office hours. When your MHP is NOT available, the BHA office staff or answering machine will take a message. In the event of any emergency and you cannot reach your MHP, please call your nearest Crisis Intervention, police, go to the emergency room and/or call 911.

**Regarding Scheduled Appointments**
BHA believes and encourages people to be responsible as part of your well-being and this extends to scheduling appointments. As a general guideline, if there are frequent no shows (two or more no shows) for a scheduled counseling appointment, BHA may consider discharging you from treatment and refer you to another mental health facility or provider.

If you leave treatment and want to resume treatment, simply contact the office to discuss reopening your treatment or explore what other treatment options may meet your current treatment needs.

**Missed or Cancelled Appointments**
The time that you are scheduled for your appointment is valuable and limited. Where permitted, and due to the prohibitive costs of late cancellations and no shows, BHA may charge you a fee of $50.00 for appointments missed or cancelled less than 24 hours in advance. If BHA can fill your time slot with another client, you will not be charged, however BHA cannot guarantee this will happen. We will make every effort possible to fill your timeslot, but it is your responsibility to call and cancel the time you have reserved. Most healthcare insurance companies and employee assistance companies do not pay for no shows and late cancellations.

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**Meetings and Fees**

Appointments last usually from 45 minutes to 1 hour in duration depending on your healthcare insurance policy or type or scope of therapy. Clients are usually seen weekly or more or less frequently as the problem dictates and you and your MHP discuss what meets your treatment needs.

**Payment**

Payment is due at the time of session unless other arrangement have been made. BHA will file your insurance claim. Please inform BHA office staff as soon as possible if there are any changes in your healthcare insurance policy. You are responsible for paying any deductibles, co-insurance and copayments, if applicable. It is your responsibility to know your insurance benefits. BHA realizes that temporary financial problems may affect timely payment of your account. If such problems arise, BHA encourages you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or have any uncertainty regarding your insurance coverage PLEASE don't hesitate to ask. Failure to pay any fees may require BHA to remit your claim to a collection agency.

****Fee Schedule is available upon request****
****Payments should be made directly to Behavior Health Associates****

I will contact Behavior Health Associates Billing department directly if my financial circumstances prevent me from making payments in a timely fashion. I authorize the release of any medical or other personal information necessary to process my insurance, employee assistance program or workmen compensation claim. I also authorize payment of medical benefits to the supplier of services provided to myself, child, or family.

******BHA Mental Health Professionals do not make custody recommendations******

**Check below to indicate custody status if client is a minor**

- o Parents are married to each other and both are legal parents of child/children.
- o I am a single parent, with legal and physical custody of child/children.
- o The child/children's other parent and I share legal custody. Consent must be obtained from other parent to continue services beyond this appointment.
- o Child is in the custody of the Commonwealth of Pennsylvania or other State.
- o Other_____

My signature below means that I acknowledge receipt, have reviewed the above statements, understand and fully agree to comply with all of the points above.

**Print Patient Name**_____

_____Date:_____
**Patient's Signature**

_____**Date**_____
**Parent**

_____**Date**_____
**Guardian Signature**

_____**Date:**_____
**Witness**

***Behavioral Health Associates, Inc.*** ***Initial Contact Sheet***

Date: _____

Patient Name_____ Date of Birth_____

Address_____ Age _____ Sex_____

_____ Marital Status_____

_____ SSN_____

| | | OK TO CALL | OK TO LEAVE MESSAGE |
|---|---|---|---|
| Phone: | (Home)_____ | Yes__ No ___ | Yes___ No___ |
| | (Work)_____ | Yes__ No ___ | Yes___ No___ |
| | (Cell) _____ | Yes__ No ___ | Yes___ No___ |

Place of employment _____ Occupation _____

Referral Source_____

**In Case of Emergency call** _____ Phone #_____

**Relationship**_____

**Family Physician** _____ Phone#_____

**Pharmacy**_____Town_____Phone #_____

**Name of insurance** _____ ID# _____

Group#_____ Authorization # _____ Co-pay_____

if you are not the subscriber (e.g. if the member on the card is your spouse or parent), we need:

Subscriber name _____ DOB_____ Employer_____

If you have secondary insurance- Name_____ ID#_____

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand and agree that I am responsible for all charges not covered by my health plan(s), and agree to pay the known non-covered charges and copayments at the time services are rendered.

_____

Signature of patient or parent/guardian if minor Date

***Behavioral Health Associates, Inc.***

***MEDICAL HISTORY***

Date _____

Name _____

DOB _____

Age_____

Sex_____

**Personal History**

Blood Pressure Problems _____ Heart Disease_____ Ulcers_____ Arthritis_____

Alcohol Use_____ Drug Use_____ Cigarette Use_____ Thyroid Problems _____

Seizures_____ Depression _____ Anxiety _____

**Allergies** _____

**Prescription Medications** _____

_____

_____

**Over-the-counter medication regularly taken** _____

_____

_____ _____

**Signature of Patient or Parent/Guardian if minor** **Date**

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# PATIENT INTAKE INFORMATION

**Patient Name:** _____

**SS#:** _____

**DOB:** _____

This form acknowledges the receipt of the following information:

1. **Your rights regarding your health information**
2. **Patient rights**
3. **Notice of privacy practices**
4. **What to do if you cannot reach the office/your therapist**

_____ _____
Patient Signature Date

_____ _____
Parent / Guardian Date

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# CRISIS PLAN

**Name:**_____ **Date**_____

**In the event that _____ presents as a danger to self or others or talks about harming self others, it is recommended to utilize the following coping skills to manage the situation and maintain the safety of all involved.**

**Coping skills that may be helpful include but are not limited to:**

**Relaxation Techniques**
**Journaling**
**Deep Breathing**
**Exercise**

**If coping skills are not helpful and _____ continues to present as a danger to self or others, utilize any or all of the following:**

**Local County Crisis:**

**Carbon County: 610-377-0773**
**Schuylkill County: 877-993-4357**
**Northampton County: 610-252-9060**
**Monroe County: 570-992-0879**
**Lehigh County: 610-782-3127**
**Luzerne County: 888-829-1341**

**Or contact 911 for assistance**

**Or go to the local emergency room for evaluation**

**Patient/Guardian Signature:** _____

**Date:**_____

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# Your Rights Regarding Your Health Information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home and not at work to cancel or schedule an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell certain individuals involved in your case, or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree we will keep our agreement excerpt if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have a right to look at the health information we have about you, such as your medical and billing records. You can even get a copy of these records, but we may charge you. Contact our Privacy Officer to arrange how to see your records.
4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some changes (called amending). You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room, and you can always get a copy of the NPP from our Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health we provide to you in any way.

If you have any questions regarding this notice, or our health information privacy policies, please contact our Privacy Officer.

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# Patient Rights

1. Patient has the right to be treated with respect
2. Patient has the right to confidentiality pertaining to treatment.
3. Patient has the right to refuse to participate.
4. Patient has the right to expect treatment to continue based on need.
5. Patient has the right to any outside treatments; however, they are responsible for the costs
6. Patient has the right to have any questions answered about treatment.
7. Patient has the right to actively participate in treatment.
8. Patient has the right to refuse or withdraw from treatment or services.
9. Patient has the right to not be discriminated against with regards to gender, national origin, religion, race, etc.
10. Patient has the right to be informed of possible side effects of medications prescribed for treatments.

If you have any complaints regarding your rights, you have the right to file a formal complaint.

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

# Notice of Privacy Practices

Our practice is dedicated to maintaining the privacy of your personal health information. We are also required by law to do this. These laws are complicated, but we must provide you with important information. This notice is a shorter version of the full, legally required Notice of Privacy Practices (**NPP**) which is posted in the waiting area, so refer to it for more information. However, we cannot possibly cover all situations so please talk to our Privacy Officer whose name is listed at the end of this notice for any questions.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment**, for services or for some other business activities which are called, in the law, health care **operations**. After you have read this NPP we will ask you to sign a **consent form** to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we, or you, want to use or disclose (send, share, release) your information for any other purpose, we will discuss this with you and ask you to sign an authorization to allow this.

Of course, we will keep your health information private, but there are sometimes when the laws require us to use or share it, such as:

- When there is a serious threat to your health or safety or the safety of another individual or the public. We will only share information with a person or organization who is able to prevent or reduce the threat.
- Some lawsuits or legal court proceedings.
- If a law enforcement official requires us to do so.
- For worker's compensation and similar benefit programs.

There are some other situations like these which do not happen very often. They are described in the longer version of the NPP.

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# Emergencies

In the event of an emergency (in danger of hurting yourself and/or others) and you are not able to reach the BHA office or your therapist:

1. Call **911**

2. Call **Crisis**:

| | |
|---|---|
| **Carbon County** | **570-992-0879** |
| | **800-849-1968** |
| **Lehigh County** | **610-782-3127** |
| **Luzerne County** | **888-829-1341** |
| **Monroe County** | **570-992-0879** |
| **Northampton County** | **610-252-0960** |
| **Schuylkill County** | **877-993-4357** |
| **Childline** | **800-932-0313** |

3. Go to the nearest **Emergency Room**

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## Consent to Obtain/Release Information

To Whom It May Concern:

The person whose signature appears below is presently a patient of Behavioral Health Associates, Inc., Outpatient Program and consents to the release of information as specified. We appreciate your cooperation and prompt response. Please send the requested information to the attention of:

**Behavioral Health Associates Outpatient Medical**

Client _____ S.S.# _____ Date of Birth _____

I, _____ hereby authorize Behavioral Health Associates, Inc.

to obtain from /release to:

PCP
_____
Name/Facility

_____
Address

Information obtained will be for the purpose of assessment and provision of services.

The information should include the following data:

- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☒ Physical Examinations
- ☐ Psychological Testing
- ☐ Neurological Studies
- ☐ Neurological Testing/Consultations
- ☐ Psycho-Social Histories
- ☒ Medical Histories
- ☐ Psychiatric Histories
- ☒ Laboratory Results
- ☐ School Records
- ☐ School Reports
- ☐ Drug/Alcohol Information
- ☐ Treatment Plans
- ☐ Intake Summaries
- ☐ Case Management Notes
- ☒ Verbal Exchange of Information
- ☒ Other: continuity of care

****This release shall remain valid for one year following signature date.**

I have been informed that according to confidentiality regulations, my signature is necessary and that this release is limited to the person/organization, the purpose, and the time indicated on this form. I also understand I may withdraw my permission at any given time, although I must do so in writing.

_____ _____
CLIENT SIGNATURE (OR PARENT /GUARDIAN) DATE

_____ _____
WITNESS DATE

If unable to provide written signature, provide for two witnesses acknowledging verbal consent.

_____ _____
WITNESS DATE DATE

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**Behavioral Health Associates Outpatient Medical**

Client _____ S.S.# _____ Date of Birth _____

I, _____ hereby authorize Behavioral Health Associates, Inc.

to obtain from / release to:

School District
Name/Facility

Address

Information obtained will be for the purpose of assessment and provision of services.

The information should include the following data:

- ☐ Psychiatric Evaluations
- ☒ Psychological Evaluations
- ☐ Physical Examinations
- ☐ Psychological Testing
- ☐ Neurological Studies
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- ☐ Laboratory Results
- ☒ School Records
- ☒ School Reports
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- ☐ Treatment Plans
- ☐ Intake Summaries
- ☐ Case Management Notes
- ☒ Verbal Exchange of Information
- ☐ Other: _____

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_____ _____
CLIENT SIGNATURE (OR PARENT /GUARDIAN) DATE

_____ _____
WITNESS DATE

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_____ _____
WITNESS DATE DATE

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**Behavioral Health Associates Outpatient Medical**

Client _____ S.S.# _____ Date of Birth _____

I, _____ hereby authorize Behavioral Health Associates, Inc.

to obtain from / release to:

Emergency Contact
Name/Facility

Address

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- ☐ Psychiatric Histories
- ☐ Laboratory Results
- ☐ School Records
- ☐ School Reports
- ☐ Drug/Alcohol Information
- ☐ Treatment Plans
- ☐ Intake Summaries
- ☐ Case Management Notes
- ☒ Verbal Exchange of Information
- ☒ Other: Scheduling / Transportation

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_____ _____
CLIENT SIGNATURE (OR PARENT/GUARDIAN) DATE

_____ _____
WITNESS DATE

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_____ _____
WITNESS DATE DATE

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**Behavioral Health Associates Outpatient Medical**

Client _____ S.S.# _____ Date of Birth _____

I, _____ hereby authorize Behavioral Health Associates, Inc.

to obtain from / release to:

Emergency Contact
Name/Facility

Address

Information obtained will be for the purpose of assessment and provision of services.

The information should include the following data:

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- ☐ Psychological Testing
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- ☐ Treatment Plans
- ☐ Intake Summaries
- ☐ Case Management Notes
- ☒ Verbal Exchange of Information
- ☒ Other: Scheduling / Transportation

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_____ _____
CLIENT SIGNATURE (OR PARENT /GUARDIAN) DATE

_____ _____
WITNESS DATE

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_____ _____
WITNESS DATE DATE

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**Behavioral Health Associates Outpatient Medical**

Client _____ S.S.# _____ Date of Birth _____

I, _____ hereby authorize Behavioral Health Associates, Inc.

to obtain from / release to:

Insurance Company
Name/Facility

Address

Information obtained will be for the purpose of assessment and provision of services.

The information should include the following data:

- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☐ Physical Examinations
- ☐ Psychological Testing
- ☐ Neurological Studies
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- ☐ Psychiatric Histories
- ☐ Laboratory Results
- ☐ School Records
- ☐ School Reports
- ☐ Drug/Alcohol Information
- ☐ Treatment Plans
- ☐ Intake Summaries
- ☐ Case Management Notes
- ☒ Verbal Exchange of Information
- ☒ Other: Insurance / Billing

****This release shall remain valid for one year following signature date.**

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_____ _____
CLIENT SIGNATURE (OR PARENT /GUARDIAN) DATE

_____ _____
WITNESS DATE

If unable to provide written signature, provide for two witnesses acknowledging verbal consent.

_____ _____
WITNESS DATE DATE

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Behavioral Health Associates Outpatient Medical

Client _____ S.S.# _____ Date of Birth _____

I, _____ hereby authorize Behavioral Health Associates, Inc.

to obtain from (release to:)

Pharmacy

_____
Name/Facility

_____
Address

Information obtained will be for the purpose of assessment and provision of services.

The information should include the following data:

- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☐ Physical Examinations
- ☐ Psychological Testing
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- ☐ School Reports
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- ☐ Case Management Notes
- ☒ Verbal Exchange of Information
- ☒ Other: Medication

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_____ _____
WITNESS DATE

If unable to provide written signature, provide for two witnesses acknowledging verbal consent.

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**Behavioral Health Associates Outpatient Medical**

Client _____ S.S.# _____ Date of Birth _____

I, _____ hereby authorize Behavioral Health Associates, Inc.

to obtain from / release to:

_____
Name/Facility

_____
Address

Information obtained will be for the purpose of assessment and provision of services.

The information should include the following data:

- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☐ Physical Examinations
- ☐ Psychological Testing
- ☐ Neurological Studies
- ☐ Neurological Testing/Consultations
- ☐ Psycho-Social Histories
- ☐ Medical Histories
- ☐ Psychiatric Histories
- ☐ Laboratory Results
- ☐ School Records
- ☐ School Reports
- ☐ Drug/Alcohol Information
- ☐ Treatment Plans
- ☐ Intake Summaries
- ☐ Case Management Notes
- ☐ Verbal Exchange of Information
- ☐ Other: _____

****This release shall remain valid for one year following signature date.**

I have been informed that according to confidentiality regulations, my signature is necessary and that this release is limited to the person/organization, the purpose, and the time indicated on this form. I also understand I may withdraw my permission at any given time, although I must do so in writing.

_____ _____
CLIENT SIGNATURE (OR PARENT /GUARDIAN) DATE

_____ _____
WITNESS DATE

If unable to provide written signature, provide for two witnesses acknowledging verbal consent.

_____ _____
WITNESS DATE DATE