Full Name (First, Last): _____

Preferred Name: _____

Check first choice for phone contact:

☐ **Home:** (____)_____ ☐ **Cell:** (____)_____ ☐ **Work:** (____)_____

Okay to ID? ☐ Yes ☐ No Okay to ID? ☐ Yes ☐ No Okay to ID? ☐ Yes ☐ No

E-mail: _____ **County:** _____

Physical
Street Address: _____ **Homeless:** ☐ Yes ☐ No

City, State, ZIP: _____ **Ok to send mail:** ☐ Yes ☐ No

If not, where do you get your mail: _____

Birthdate: _____ **Birth sex:** ☐ Male ☐ Female

Do you think of yourself as:
☐ Lesbian, gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Choose not to disclose

What is your current gender identity?
☐ Identifies as Male ☐ Identifies as Female ☐ Transgender Male ☐ Transgender Female
☐ Neither exclusively male nor female ☐ Choose not to disclose

Race: (check 1 or more)
☐ Amer. Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Middle eastern or North African
☐ Native Hawaiian/Pac Island
☐ White
☐ Other Race
☐ Declined to Specify

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Declined to Specify

Marital Status:
☐ Never Married
☐ Married
☐ Widowed
☐ Divorced
☐ Separated

Tobacco Use: ☐ Smoker ☐ Non-Smoker **Smoking Status:** ☐ Current every day smoker ☐ Current someday smoker ☐ Former Smoker ☐ Never Smoked ☐ Chews Tobacco ☐ Snuff user ☐ Electronic Cigarette

Primary Language: _____ **Language Preference, if not English:** _____

☐ **Need services of interpreter.** ☐ **Need ASL interpreter.**

Veteran: ☐ Yes ☐ No **Social Security number:** _____

Employment Status:
☐ Employed
☐ Unemployed
☐ Not in Labor Force
☐ Not Available

If employed, where do you work: _____

Guarantors

Emergency contact may be made to persons listed above for purposes related to treatment in the event client cannot be reached. In case of emergency, Ouachita Behavioral Health and Wellness will request or release only information which is essential to handle the emergency.

	Name and Address	Phone Number	Relationship
Guardian/Parent 1			
Guardian/Parent 2			
Contact Person 1			
Contact Person 2			

Payment Source Information

☐ **Check if you do not have any insurance**

Medicaid/PASSE Number:_____ Medicare Number: _____

Care Coordinator: _____ Contact Number: _____

Primary Insurance Company: _____ Group #/ID#:_____

Name Insurance Under: _____DOB: _____ Rel. to Client:_____

Address:_____ Phone: _____

Social Security #:_____ Company: _____Group #/ID#: _____

Responsible for Payment ("Same" if insurance holder is responsible):
Name:_____ Phone: (____) _____

Clinician Preference: ☐ Male ☐ Female

Telephone Contact: OBHAW may need to contact you regarding a change or cancellation of your appointment, a treatment emergency, or appointment reminder. May we:

☐ Yes ☐ No Leave a message on your answering machine/voice mail?
☐ Yes ☐ No leave a message with a person at your home number?
☐ Yes ☐ No Contact you at your work number?

Which method do you prefer for appointment reminders? ☐ **Phone Call** ☐ **Text** ☐ **NONE**
First choice for phone contact: ☐ **Home** ☐ **Cell** ☐ **Work**

Living Situation:

☐ Private Residence
☐ Foster Home
☐ Residential Care
☐ Crisis Residence
☐ Children's Residential
☐ Institutional Setting
☐ Jail/Correctional Facility
☐ Homeless Shelter
☐ Other

Primary Care Physician:

_____ **Phone number:** _____

How did you find OBHAW?

☐ Family/Friend
☐ Primary Care Physician or other doctor
☐ Online (internet search or social media)
☐ Community Agency
☐ School Counselor/Administrator/Teacher
☐ Returning Client
☐ Other (please specify)_____

Legal Status:

☐ Voluntary
☐ Court
☐ DHS
☐ Juvenile Probation
☐ Law Enforcement

For Children under Age 18

Legal Custody:

☐ A Foster Parent
☐ B Both Mother Father, Married
☐ D Dept. of Human Services
☐ F Father
☐ G Grandparent
☐ J Joint Custody
☐ M Mother
☐ U Aunt and/or Uncle
☐ O Other _____

Attending School: ☐ 1 Yes ☐ 2 No

School Attending: _____

☐ Yes ☐ No Child receiving Special Education Services
☐ Yes ☐ No Child involved in Juvenile Justice System
☐ Yes ☐ No Child involved in FINS
☐ Yes ☐ No Child involved in Division of Youth Services

Ouachita Behavioral Health and Wellness (OBHAW)
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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We will never share any Substance Abuse Treatment records without your written permission except where required by law and will maintain your right to confidentiality in accordance with 42 CFR Part 2.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

We will never share any substance abuse treatment records without your written permission.

Effective Date: January 16, 2020

Privacy Officer: Jane Sherrill **Phone:** 501-620-5119 **Email:** janes@obhaw.org

Established in 1969, Ouachita Behavioral Health and Wellness, is a community mental health center serving the residents of Clark, Garland, Hot Spring, Montgomery, and Pike counties. OBHAW is a private, not-for-profit organization which charges fees for services. OBHAW also bills third-party sources such as insurance, Medicare, and Medicaid.

Administered by the Arkansas Department of Human Services (DHS), Medicaid is a program that helps pay for medically necessary services for needy and low-income persons. OBHAW is certified as a Medicaid provider of Outpatient Behavioral Health Services (OBH). Core OBH services include Individual and Family Therapy, Psychiatric Evaluation, Medication Management, Intervention Services, and Crisis Services.

Even if you have Medicaid, you may not have coverage for OBH services. Prior to receiving treatment services, an evaluation must be performed by a qualified mental health professional for admission into an OBH Program. The evaluation is a written assessment that evaluates your mental condition including assessment for serious mental illness (adults) or serious emotional disturbance (children) and, based on your diagnosis, determines whether treatment in the OBH Program is appropriate. If appropriate, a plan for your care appropriate to your needs, including services to be provided, will be prescribed by an OBHAW physician. For more information on Medicaid and OBH rules, visit www.medicaid.state.ar.us.

OBHAW charges a fee for serving as a representative payee for Social Security/SSI beneficiaries who are enrolled in our money management services.

OBHAW prohibits discrimination to all individuals by adhering to the Civil Rights Act of 1964 Title VI, 42 U.S.C. 2000d et seq. ("Title VI"). Title VI prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives Federal funds or other Federal financial assistance. Programs that receive Federal funds cannot distinguish among individuals on the basis of race, color or national origin, either directly or indirectly, in the types, quantity, quality or timeliness of program services, aids or benefits that they provide or the manner in which they provide them.

STATEMENT OF CLIENT RIGHTS

These are the rights to which you are entitled as a client of Ouachita Behavioral Health and Wellness.

1. You are entitled to receive services offered by Ouachita Behavioral Health and Wellness regardless of sex, race, color, religion, national origin, age, and degree of disability, as long as OBHAW has the capabilities and/or facilities to provide the treatment indicated. OBHAW staff members will have the ability to communicate and interact effectively with people of different cultures, including people with disabilities, limited English proficiency, and atypical lifestyles.
2. You have a right to confidentiality. Client records are available to OBHAW staff members only as needed for treatment, payment, or healthcare operations.
3. No information about you may be released to any other agency or individual without your prior written consent or consent of your parent or legal guardian. This includes any form of protected health information (for example, correspondence, treatment plan, or conversation in or out of OBHAW clinics). EXCEPTION is the release of information needed for treatment, payment, or healthcare operations, by court order, or in emergency situations involving your safety or the safety of others. Only the information required to deal with the situation may be released.
4. You have the right to obtain access to personal health information as stated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
5. Photographs other than for identification purposes and sound or video recordings may not be made of you without written permission.

6. You have the right to be treated with dignity and respect.
7. You have a right to a program of treatment especially designed for your individual needs. Treatment services will be provided only when those services are applicable to your treatment needs.
8. You have a right to appropriate assessment of pain in determining treatment needs.
9. You have a right to refuse treatment offered, unless there is an immediate danger to yourself or others. However, if you refuse to cooperate or participate in a recommended treatment (for example, counseling or day treatment when receiving medication), OBHAW may limit services.
10. You have the right to not be denied treatment based on your actual or perceived sero status, HIV related condition, or AIDS.
11. You have a right to be informed of risks, benefits, and side effects of treatment.
12. You have a right to reasonable privacy during treatment. This means also that OBHAW staff are not allowed to search for you on the internet or interact with you on social media or other virtual platforms.
13. You have a right to a written copy of the OBHAW Privacy Practices.
14. You have the right to terminate services and to receive notice before OBHAW terminates or suspends your services.
15. You have a right to complain if you think your or someone else's rights have been violated.

RESPONSIBILITIES AS A CLIENT

In addition to your rights while receiving treatment, you also have a number of responsibilities to yourself and to OBHAW.

1. You have the responsibility to participate actively and honestly in your treatment. In many cases, particularly when the client is a child or adolescent, effective treatment requires active involvement and participation of parents or other family members.
2. You have the responsibility to be on time for your scheduled appointments and to give 48-hour notice if you will be unable to keep an appointment. If 2 appointments in a three-month period are missed without notice, services may be discontinued.
3. If you are receiving medication management services and therapy services are recommended as part of your treatment plan, you are expected to keep therapy appointments. If you do not keep recommended therapy appointments, you may be referred out for medication management.
4. You have the responsibility to treat other clients and OBHAW personnel with dignity and respect.
5. No weapons are allowed on OBHAW property
6. You are responsible for asking questions about any policy, procedure, or treatment which you do not understand or with which you do not agree.
7. You are responsible for carefully reading and understanding any papers you may be asked to sign in relation to your treatment.
8. You have the responsibility to honor your financial contract by paying for the services you receive at the agreed-upon times and/or terms. You are responsible for providing OBHAW with all information necessary for billing other payers. Medicaid OBH payments may be denied based on third party payer's policies or rules. If services are not covered by Medicaid or insurance, you are responsible for payment.
9. You are responsible for any medical costs incurred from outside medical providers when services are arranged by OBHAW or when you are transported by OBHAW to receive treatment.

Therapeutic Services

Different types of therapy such as individual and group which may occur at a variety of settings (OBHAW facility, school, home, off-site, etc.). A counselor or social worker is a trained clinician who specializes in a variety of disciplines to help understand and treat mental illness and behavioral issues through individualized strategies, goals and activities.

What your Therapist can do:

Clarify feelings

Provide guidance/ support

Provide parenting strategies

Assist in life decisions

Develop treatment goals

Education of diagnoses

Social and life skills

Diagnosing mental conditions

What your Therapist cannot do:

DOES NOT PRESCRIBE MEDICATION (refer all medication questions to Psychiatrist/ Nurse APN)

What to expect at your therapy appointment: Appointment time means the time you are scheduled to see your therapist and you should arrive a few minutes early to pay copays and meet with Financial Case Manager as needed. The therapist will see you to discuss problems that interfere with your behavioral and emotional functioning.

Psychiatric Services

A psychiatrist is a medical doctor who specializes in preventing, diagnosing and treating mental illness. These services are provided by a Psychiatric Doctor or Psychiatric Nurse Practitioner.

What your Psychiatrist/ Nurse APN can do:

Prescribe medications

Diagnose mental conditions

Discuss how physical conditions and medications affect mental illness

Differentiate mental health problems from other medical conditions

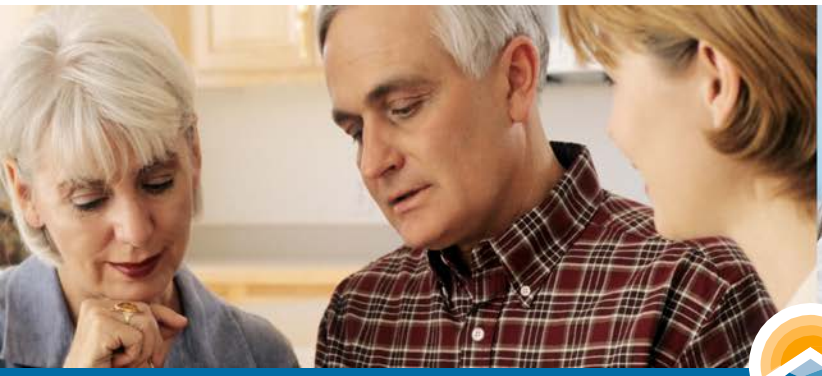
What your Psychiatrist/ Nurse APN cannot do:

DOES NOT ENGAGE IN THERAPY (refer all therapy questions to clinician)

DOES NOT CONDUCT TESTING (discuss issues of testing with your therapist for appropriate referral).

What to expect at your Psychiatrist/ Nurse APN appointment:

Appointment time means your arrival time at the clinic to see the Nurse, pay copay, visit with Financial Case Manager, etc. There will be a wait time beyond the appointment time to see the Psychiatrist/ APN but you will be seen as close to that appointment time as possible after you go through the other steps



TREATMENT INFORMATION

Commitment to Treatment Agreement

Client Name: _____ Case # _____

Treatment at Ouachita Behavioral Health and Wellness is a team effort. For treatment to be most effective, it is both essential and required that clients, parents and/or guardians work together with their therapist to develop and follow a treatment plan. *Please note that only prescription medications that must be taken during program hours are allowed on premises or the person.* **The following is a list of expectations for clients, parents, or guardians in order to remain in treatment at OBHAW.**

- ____ (initial) Comply with treatment recommendations agreed on by you and your therapist included on your Treatment Plan.
- ____ (initial) Schedule and attend all individual and family sessions as recommended on your Treatment Plan.
- ____ (initial) Regularly review your treatment goals and objectives with your therapist. Speak up if you disagree with the goals. For clients with Medicaid Tier 2, sign your Treatment Plan at least every 180 days.
- ____ (initial) Keep all Primary Care Physician referrals up to date (this includes well child checkups if the PCP requires). If you fail to have required referral, OBHAW will suspend all services except Crisis Intervention Services until the PCP referral is received.
- ____ (initial) Provide OBHAW with updated information when there is a change in address, phone number, payment source, guardianship, or other related information.
- ____ (initial) **Attend and arrive on time for all scheduled therapist and doctor appointments. Call at least 48-hours in advance, if you need to cancel.**
- ____ (initial) If you miss two scheduled appointments without 48-hr notice within a three month period, OBHAW may choose to discontinue services.
- ____ (initial) **If you miss your first appointment, you may be discharged and may not be reopened for 3 months.**
- ____ (initial) Medicaid Tier 2 requires an initial and yearly Physician's Diagnostic Assessment (PDA). If you miss this appointment, OBHAW will suspend all services except Crisis Intervention Services until the PDA is completed.

We want to work with you collaboratively in order to provide the best treatment possible. The only way that we can do this is for you to participate willingly and cooperatively in all areas of treatment. If any of the above conditions are not met, it may be determined by the treatment team that we can no longer offer the appropriate and necessary treatment. It is important that you and the treatment team work collaboratively to ensure the best possible care. Thank you so much for your cooperation in this area.

Client/Parent/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Case #: _____

Medicaid Tier 1 Clients

I understand that under the new Medicaid Rules, Medicaid now requires me to have a PCP referral from my Primary Care Physician.

If I don't have a PCP referral from my primary care doctor, I understand that I can only receive a maximum of ten (10) services and then my services will cease. If the PCP referral is not received within 30 days after the third service then my chart will be closed.

Client Signature **Date**

_____ _____

CONSENT FOR TREATMENT and PAYMENT AGREEMENT
CONSENT FOR USE OF PROTECTED HEALTH INFORMATION

Client Name (Last, First): _____ Case #: _____

Consent for Treatment. I, the undersigned individual, do hereby give my permission to be treated by assigned OBHAW treatment staff. This may include, but not be limited to, evaluation, diagnosis, psychotherapy, day treatment, intervention, emergency crisis services, and consultation with other OBHAW staff, in person or via telehealth. I acknowledge that OBHAW is certified as an Outpatient Behavioral Health Agency by the Arkansas Department of Human Services Division of Adult, Aging and Behavioral Health Services to provide services to Medicaid eligible beneficiaries that have a Behavioral Health diagnosis as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-5 and subsequent revisions) I further acknowledge and understand that eligibility for services with OBHAW depends on my needs, and services provided must be medically necessary. I have been provided an explanation of the definition of Serious Mental Illness/ Serious Emotional Disturbance as it relates to my/my child's care. "Serious Emotional Disturbance" (SMI) is defined as individuals from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual of Mental Disorders.. "Serious Mental Illness" (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. SMI applies to individuals age 18 and over.

I understand that it is my right to ask questions if I need clarification or have concerns. My photo may be taken for identification purposes. I have received and discussed copies of "Client Rights and Client Responsibilities," "OBHAW Payment Policies," and "Notice of Privacy Practices."

If the client is a minor, I hereby affirm that I am the legal guardian or a representative of an agency or organization with legal custody and, hereby, consent to his/her treatment and accept financial responsibility for services provided under this agreement.

Payment for Services. I understand that OBHAW charges a fee for services based on the fee schedule. This fee schedule is subject to change and clients will be notified of any changes. OBHAW reserves the right to discontinue services if prompt payment is not made. Payment in full is required at the time of service unless coverage is verified or a payment contract is signed. If third-party (insurance) payments or co-payments result in an overpayment, OBHAW will refund the overpayment. OBHAW will bill third party providers such as Medicaid, Medicare or private insurance if I furnish the required documents. I will be responsible for any co-payments or payment for any services not covered by a third party provider.

OBHAW charges a fee for providing professional services for consultation relative to legal cases including testimony, travel time, deposition, phone consultation, or written report in addition to client records. If OBHAW receives a subpoena on your behalf, you are responsible for any additional charges incurred in conjunction with that subpoena, including time required to prepare documents and/or time/travel for testimony.

Assignment of Benefits. I, the undersigned individual, do hereby assign my right to receive payment of authorized benefits from third-party providers to Ouachita Behavioral Health and Wellness (OBHAW). I request that payment of authorized benefits be made on my behalf to OBHAW for any services furnished to me by OBHAW service providers. I authorize OBHAW the right to collect and pursue payment from the third party provider including but not limited to filing an appeal on my behalf for any denial of payment and/or adverse benefit determination related to the services and care received by OBHAW. I understand that I am personally responsible, according to the OBHAW fee scale, for all charges not paid by the third-party provider. I further acknowledge and agree that this assignment of benefits applies and extends to all subsequent services, visits and appointments provided by OBHAW. I certify that I have read and understand the statements on assignment of benefits and that all of my questions have been answered to my satisfaction, and that I agree with each statement.

_____

Client/Court-Appointed Legally Responsible Person Date

Privacy and Confidentiality. Protected health information may be used and disclosed to carry out treatment, payment, or health care operations (TPO). I, the undersigned individual, do hereby give my consent for OBHAW to release information (including date and nature of service, diagnosis, clinical information, and anticipated length of treatment) as needed for TPO to my insurance company, Medicaid, Title XX, the Arkansas Department of Human Services, or other third-party provider. This information will be used to process claims and may not be re-released by the third-party provider. OBHAW may contact my primary care physician to coordinate treatment or in order to obtain a PCP Referral when required by my reimbursement source. OBHAW may also exchange information with other healthcare providers with whom I have a treatment relationship. Information requested may include alcohol/drug or HIV/AIDS related treatment. I have the right to request that use of this information be restricted. OBHAW will abide by the request for restriction when not prevented or superseded by law or other circumstance. Any agreement to restrict use of protected health information is binding barring an Exception Disclosure.

In accordance with state and federal laws including 42 CFR Part 2, information maintained about me by OBHAW will be protected from further disclosure without a specific written authorization and in accordance with the current OBHAW Notice of Privacy Practices which is available and posted in all OBHAW offices. Any changes to these practices will be posted and available by request.

Exception Disclosure is permitted under state and federal laws for situations which may be applicable to me such as

1. In the interest of public safety (life threatening situations)
2. In response to a court order
3. Where state laws requires that information be disclosed (*e.g.*, suspected child or adult abuse)

In case of emergency, I authorize OBHAW to release only information which is essential to handle the emergency.
A release for any other purpose other than those stated herein shall require a separate authorization specific to that request.
I have the right to revoke this consent in writing, except to the extent that OBHAW has taken action in reliance upon this consent.

_____

Client/Court-Appointed Legally Responsible Person Date

☐ _____(Optional) I give permission for (Name) _____ to exchange information about my treatment by talking with OBHAW staff and/or picking up medication or other treatment-related materials for me which may contain protected health information.

Telemedicine at Ouachita Behavioral Health and Wellness

As a member of the Arkansas Telehealth Network, Ouachita Behavioral Health and Wellness is able to provide real-time services from distant treatment staff through interactive video telemedicine, allowing clients to receive needed health care from the nearest OBHAW office. OBHAW is a participant in the Arkansas e-Link initiative, a project led by UAMS. This venture was designed to increase broadband capacities and interactive video equipment at over 450 entities in Arkansas. OBHAW has videoconferencing equipment in all of our clinics which allows clients to see our physicians or therapists from any site which is on the network, similar to seeing distant family members via Skype.

Arkansas Medicaid, Medicare, BCBS and Tricare will pay for telemedicine services with a physician or therapist for almost all services provided by OBHAW on a face-to-face basis. A OBHAW staff member will meet with the client prior to a telemedicine session to take vital signs and review medications. The staff member is available to the client during the telehealth session to assure that the equipment is working properly. The equipment meets all requirements of HIPAA law and the audio-video standards of the Arkansas Telehealth Network for real-time, two-way interactive audiovisual transmissions.

All telemedicine services provided at OBHAW are directed toward reducing the symptoms of mental illness and maximizing the functioning of the client. Delivery and administration of all telemedicine services conform to state standards, and rationale for use and goals for treatment are documented and consistent with the individual's Master Treatment Plan.

Service via telemedicine are provided only from approved sites with equipment that meets the standards for telemedicine services. The same client rights and responsibilities are applicable to telemedicine services as services provided face to face in the same office. These services allow OBHAW clients to have access to experienced and effective psychiatrists without limitations.

If the client is not feeling satisfied with telehealth treatment for any reason, discuss this directly with the staff member enabling the treatment. Technology assisted sessions (telemedicine) have drawbacks compared to face to face sessions, among those being the lack of “personal” face-to- face interactions, the lack of visual cues including body language and facial expressions in the therapy process. Not all insurance companies will cover telemedicine services. If at any time OBHAW does not feel like you are going to benefit from technology assisted services, you will be referred to face to face traditional services.

Acknowledgement
I have received and reviewed the information above on telemedicine and consent to receive services via telemedicine.

_____ _____
Client Name – PLEASE PRINT Date of Birth

_____ _____
Client or Parent/Guardian Signature Date

OBHAW Office Numbers
Hot Springs – 501-624-7111 - Arkadelphia – 870-246-4123 - Malvern – 501-332-5236- Glenwood-870-782-0179 - Mt. Ida-870-867-2147

24-Hour Emergency Telephone
624-7111 in Hot Springs
1-800-264-2410 Statewide

OBHAW Agreement for New/Current Clients Who Are Taking Benzodiazepines:

Benzodiazepines are controlled substances because of potential for dependence. The most common of these medications include Valium (diazepam); Xanax (alprazolam); Ativan (lorazepam); Restoril (Temazepam); and Klonopin (clonazepam). Opioids are also controlled substances and include hydrocodone, oxycodone, methadone and codeine.

- Combining an opioid and a benzodiazepine can slow or stop your breathing.
- Combining an opioid and a benzodiazepine can cause accidental overdose. This is when your body has too much medication but you did not know. It can cause you to stop breathing and die.
- The risk of accidental overdose can occur with any dose, large or small, even if you have been taking the medications for a long time.

In addition to risk of dependence or addiction, benzodiazepines also have other risks:

- Falls
- Memory problems and possibly dementia
- Legal consequences if you drive while under the influence
- Worsening of anxiety with long term use
- Prevention of your progress in therapy with your counselor or therapist
- Risk of respiratory suppression and death if combined with alcohol or other sedatives
- Risk of potentially fatal withdrawal if you become addicted then stop suddenly

These medications are best used short term and at the lowest dose necessary while allowing a patient to develop the skills and tools to achieve their treatment goals.

Due to the risks associated with benzodiazepines, Ouachita Behavioral Health and Wellness, has specific rules to be followed by **all** clients who are prescribed these medications. **Please review and initial each item listed below. l. Should you have any questions, please ask.**

1. Only **one** physician prescribes the benzodiazepine. If we find out that another physician is prescribing the same or another benzodiazepine for you, we will cancel your prescription from OBHAW. _____

2. The dosage of your benzodiazepine must not be exceeded. If you run out of the medication because of overtaking it, we will **not** authorize an early refill. Refills on benzodiazepines must last 30 days. _____

3. Benzodiazepines can be sold on the street. Therefore, you need to protect your medication from being stolen. OBHAW is not responsible for lost or stolen medications. _____

4. Excuses for lost or stolen prescription medications will only be accepted **one** time and only if a copy of a police report is provided to OBHAW for review. _____

5. You must keep all appointments. Failure to keep an appointment with your physician will result in you not getting a refill of your benzodiazepine. OBHAW physicians will not provide partial prescriptions of benzodiazepines due to missed appointments. _____

6. Benzodiazepines will be stopped immediately if there is evidence of either alcohol or illegal drug use. OBHAW reserves the right to perform random urine drug screens if there is any suspicion of illegal drug use or diversion of the benzodiazepine. _____

7. Your prescription will be cancelled at the pharmacy if OBHAW staff has evidence/reason to believe that you are selling your benzodiazepine or sharing it with others. _____

Counseling and therapy are essential components of treatment for anxiety and/or panic disorders. Therefore, it is necessary for you to attend regular therapy sessions (this can be individual or group sessions) and *actively participate in the therapeutic process*. Medications are not a substitute for therapy. If counseling appointments are not kept, then OBHAW will consider you non-compliant with treatment, discontinue the prescribed benzodiazepine, and you will run the risk of having your chart closed. An example of non-compliance would be if you miss two consecutive therapy appointments in a 3 month period.

It is important that you do not stop taking your medications without talking to your provider first. Stopping medications too fast can be dangerous. What you should do now:

1. Talk to your provider about the risks and benefits of your medications.
2. Ask your provider if there are safer medication options for you.
3. Ask your provider if Naloxone (Narcan) is right for you.

What is Naloxone (Narcan)?

Naloxone is an important part of opioid safety and can lower your risk of an opioid overdose death.
Naloxone is a prescription medication used in an emergency. It can help you start breathing again by reversing an opioid overdose.
Anyone can purchase Narcan (Naloxone) Nasal Spray directly from a pharmacist without a doctor's prescription. It can be purchased at most pharmacies. You can go to www.narcan.com/patients/how-to-get-narcan and present to your pharmacist to obtain Narcan (Naloxone) Nasal Spray today.

I have read the above agreement and understand the consequences of failure to comply with these requirements.

_____ _____

Name **Date**

Authorization for the Release of Protected Health Information

RE: (Client Name):	Case #
Social Security #:	Date of Birth:

Between Ouachita Behavioral Health & Wellness Attention:

And

Name or Organization:	Attention:
Address:	Phone:

TYPE, PURPOSE, and CONTENT (May check Yes for #1 OR #2, not both. May check Yes on #3 alone or in combination with #1 or #2)

☒ Yes ☐ No 1. Release of records from another agency to Ouachita Behavioral Health & Wellness

☐ Yes ☒ No 2. Release of records from Ouachita Behavioral Health & Wellness to another agency

☒ Yes ☐ No 3. Exchange of verbal information for service coordination and behavioral health treatment consultation.

Purpose of Release:

☐ Coordination of Service ☐ Disability Determination ☐ School Coordination
☐ Legal ☐ Personal ☐ Other (Specify)

Release Records from Dates: ☐ Starting _____ Ending _____
☐ Current admission through expiration of this authorization

I hereby authorize the release of the following information (nature of information, as limited as possible):

☐ MH Initial Assessment ☐ MH Therapy Progress Notes ☐ Substance Abuse (SA) Assessment
☐ MH Treatment Plan/Review ☐ MH/SA Med Checks ☐ Substance Abuse (SA) Treatment Plan
☐ MH Psychiatric Evaluation ☐ MH Discharge Summary ☐ SA IOP Progress notes
☐ MH Psychological Report ☐ Court Progress Report ☐ SA Discharge Summary
☐ Correspondence and materials from other agencies
☐ Other: _____

I understand that general medical/psychiatric records sometimes contain references to drug/alcohol use, communicable or sexually transmitted diseases as well as AIDS (Acquired Immune Deficiency Syndrome) and HIV (Human Immunodeficiency Virus) test results.
I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that by selecting the Mental Health (MH) and/or Substance Abuse documentation listed above and signing this release, I am consenting to the disclosure of records protected by 42 CFR Part 2.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires within 90 days of signature or with the following date, event, or condition:

_____

Date: _____

_____
Signature of Client

_____
Signature of Parent, Guardian, or Authorized Representative
When Required (Note relationship)

A photostatic or faxed copy of this authorization shall be as valid as the original.
Federal Regulation (CFR Part 2) prohibits the recipient from making any further disclosure if it is without the specific written consent of the person to whom it pertains. If the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Authorization for the Release of Protected Health Information

RE: (Client Name):	Case #
Social Security #:	Date of Birth:

Between Ouachita Behavioral Health & Wellness Attention:

And

Name or Organization:	Attention:
Address:	Phone:

Clients School District

☐ Arkadelphia ☐ Lake Hamilton ☐ Caddo Hills ☐ Oden ☐ Hot Springs ☐ Malvern ☐ Mountain Pine

☐ Magnet Cove ☐ Lakeside

Arkansas Dept. of Human Services:	Attention:
	Phone:

County Juvenile Court: Attention:

☐ Garland ☐ Clark ☐ Hot Spring ☐ Montgomery ☐ Pike

☐ Primary Care Doctor Name:
☐ Ouachita Childrens Center Attention:
☐ Legal Counsel Name:
☐ Foster Parents Name:
☐ Other: Attention:

TYPE, PURPOSE and CONTENT

By nature of school-based programs, the school your child attends is included in the treatment team, and ongoing exchange of information is needed for service coordination and behavioral health treatment consultation. This may include, but is not limited to, grades, treatment progress report, diagnosis, discipline reports, absentee report, medications, goals, family issues, and situation relevant to treatment. There may also be occasion to exchange information with the above-checked entities for the purpose of treatment or protection of the child. This exchange may include by is not limited to treatment progress, diagnosis, discipline problems, grades, medications, family issues, discharge information, and situations relevant to child's well-being

- The signature of the client's parent, guardian, or authorized representative at the bottom of this release authorizes OBHAW staff to ongoing exchange of both verbal and written information with the agencies or individuals names above.
- I understand that if I do not wish to have the school involved in treatment for my child, I can choose at any time to have my child transferred out of the school-based program to an outpatient office for treatment.
- If exchange of information with the Juvenile Court becomes necessary, this exchange may take place in open courtroom.
- I understand that I may revoke this consent any time, except to the extent that action has been taken in reliance on it, and that this consent is valid until discharged.

Correspondence and materials from other agencies will not be re-released without their specific permission.

Date:_____ _____

Signature of Client

_____

Signature of Parent, Guardian, or Authorized Representative when required
(Note Relationship)

I understand that general medical/psychiatric records sometimes contain references to drug/alcohol use, communicable or sexually transmitted diseases as well as AIDS (Acquired Immune Deficiency Syndrome) and HIV (Human Immunodeficiency Virus) test results.
I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Federal Regulation (CFR Part 2) prohibits the recipient from making any further disclosure if it is without the specific written consent of the person to whom it pertains. If the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Ouachita Behavioral Health & Wellness
BEHAVIOR PROBLEMS CHECKLIST

Client (Last, First):	Case #:	Date:
Parent/Guardian Providing Information:		

Information from Parent/Guardian:

Check the problem areas than concern you regarding your child:

- ☐ Aggressive
- ☐ Alcohol/drug use
- ☐ Always wants to be perfect
- ☐ Angry
- ☐ Argues
- ☐ Bad grades
- ☐ Behaves in strange ways
- ☐ Can't concentrate
- ☐ Clumsy
- ☐ Cries a lot
- ☐ Daydreams
- ☐ Defies authority
- ☐ Destructive
- ☐ Easily bored
- ☐ Fears
- ☐ Feelings easily hurt
- ☐ Feels worthless
- ☐ Few friends
- ☐ Gang involvement
- ☐ Health problems
- ☐ Immature
- ☐ Impulsive
- ☐ Inappropriate sexual behavior
- ☐ Lies
- ☐ Nightmares
- ☐ Overly active
- ☐ Overweight
- ☐ Physically abused
- ☐ Poor appetite
- ☐ Restless
- ☐ Runs away
- ☐ Sad
- ☐ School behavior problems
- ☐ Sexually abused
- ☐ Shy
- ☐ Skips school
- ☐ Sleep problems
- ☐ Stares
- ☐ Steals
- ☐ Talks about hurting self/suicide
- ☐ Tantrums
- ☐ Threatens others
- ☐ Tired
- ☐ Underweight
- ☐ Wets the bed
- ☐ Withdrawn
- ☐ Worries

The **MOST IMPORTANT** area of concern is:

Please check any recent changes which have occurred in your child's life:

- ☐ Change in friends
- ☐ Changed schools
- ☐ Death of family member
- ☐ Death of friend
- ☐ Death of pet
- ☐ Divorce
- ☐ Family member left
- ☐ Friend moved away
- ☐ Moved (different house)
- ☐ Moved (different town)
- ☐ New family member
- ☐ Parent lost job

Additional information, which is important concerning your child:

NEW CLIENT BACKGROUND INFORMATION

Name: _____Date:_____

Check any of the following that apply to you:

- ☐ Current Suicidal feelings
- ☐ Current Desire to harm others
- ☐ Anxiety
- ☐ Depression
- ☐ Family Problems
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Recent Psychiatric Hospitalization

I AM HERE FOR:

- ☐ School Based Services
- ☐ CLIMB
- ☐ DWI Assessment
- ☐ SUBOXONE/OPIOID TREATMENT
- ☐ Substance Abuse Treatment
- ☐ Court/DHS ordered assessment
- ☐ Therapy/Counseling
- ☐ Medication only

Reason for coming in today (Brief) _____

_____

Appetite Assessment: ☐ Good ☐ Fair ☐ Poor ☐ Can't Stop Eating

Sleep Assessment: ☐ Good ☐ Trouble Sleeping ☐ Excessive Sleeping

Currently experiencing pain? ☐ No ☐ Yes. If yes, rate from 1 (low) to 10 (high): _____

If yes, source of pain: _____

Any psychiatric hospitalizations within the last year? ☐ No ☐ Yes How many? _____

Past outpatient mental health treatment: ☐ No ☐ Yes Where? _____

_____

Family mental health problems: ☐ No ☐ Yes _____

Current tobacco use: ☐ None ☐ Yes. How much? _____

Does client have history of use/abuse of the following:

Alcohol: ☐ Never ☐ Current ☐ Past

Marijuana/PCP: ☐ Never ☐ Current ☐ Past

Amphetamines: ☐ Never ☐ Current ☐ Past

Cocaine: ☐ Never ☐ Current ☐ Past

Opiates: ☐ Never ☐ Current ☐ Past

Prescription Drugs: ☐ Never ☐ Current ☐ Past

Other (List): ☐ Never ☐ Current ☐ Past _____

Past Substance Abuse Treatment? ☐ No ☐ Yes When/Where? _____

Any jail stays in the last year? ☐ No ☐ Yes How many? _____

Primary Care Physician _____ Approximate Date of Last Visit _____