Samaritan
Behavioral Health

Thank you for your referral to Samaritan Behavioral Health, Inc.

CSD Referrals are to be made by completing the attached CSD Intake Packet and sending it to:

Samaritan Behavioral Health, Inc.
Preble County
225 N. Barron Street
Eaton, Ohio 45320

or Faxing to 937-456-2208

Referrals to Samaritan Behavioral Health outpatient services must contain the following information checklist items in order to meet regulatory requirements and initiate our diagnostic assessment. After we have received the **completed** information, we will contact the foster parent to schedule an intake appointment.

Intake Packet Checklist - Please complete & send the following information to our Preble office:

- ❑ The CSD Intake Referral Information form, which includes reason for referral and relevant social/family history
- ❑ Health History Questionnaire
- ❑ A signed Release of Information for the foster parent unless it is requested that they not be a part of the assessment or treatment process.
- ❑ A signed Telehealth Consent
- ❑ A signed Consent for Treatment and Financial Authorization, giving permission to SBHI to treat.
- ❑ A signed HIPAA / Documentation & Client Services Review
- ❑ Any additional signed releases for other persons, agencies, or schools should be included. A release of information is not necessary between Samaritan Behavioral Health and your organization since you have custody of the child. Release forms can be photocopied.

We will also need a copy of the current Custody Order or a statement on agency letterhead stating that your agency currently has custody of the child. This item is MANDATORY. It must be received before an appointment will be scheduled.

If you have questions about the enclosed information, please call 937-456-1915. You may fax or mail the information to us. Thank you for your assistance and cooperation.

Sincerely,

SBHI - Preble County
Phone: 973-456-1915
Fax: 937-456-2208

Samaritan Behavioral Health, Inc. (SBHI)

CSD INTAKE REFERRAL INFORMATION (please print)

Referral Date: _____ Person Completing form: _____ Phone: _____

Caseworker Name: _____ Caseworker Phone: _____

Child's Name: (Last, First, MI) _____

DOB: _____ Gender: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Social Security #: _____ Medicaid #(12 digits): _____

Caretaker Name: _____ Phone: _____

Caretaker Address: _____

Family Size: _____

Current Medications: _____

_____

Lethality/Safety Issues: _____

_____

_____

School/Grade/Special Education Placement: _____

_____

Previous Counseling History: _____

Relevant Social History Including Placement History, Number of Disruptions, and Family History:

_____

_____

_____

_____

_____

_____

Recommendations/Requests/Reason for referral: _____

_____

_____

_____

SAMARITAN BEHAVIORAL HEALTH, INC. (SBHI)
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize disclosure of health information for the release, review, sharing and exchange of the following information relating to my care from Samaritan Behavioral Health, Inc. and "Person or Entity" as identified below. This release covers all programs of Samaritan Behavioral Health, Inc. (SBHI): *SBHI-Atrium; Integrated Care Solutions; SBHI-CAM; SBHI-Miami County; SBHI-Preble; Substance Abuse Services; School Services; and Young Children's Assessment and Treatment Services (YCATS).*

Release of Information Expiration – This authorization will remain in effect until revoked or (choose one option):

❑ Date of discharge with SBHI; or ❑ Date specified by the patient (1-year max) _____

Samaritan Behavioral Health, Inc. (SBHI) SBHI is a Covered Entity/Part 2 Program.

AND

Name of Individual, Agency or Entity: _____

Person or Entity Category: ❑Individual ❑Treatment Provider ❑Training/Research ❑3rd Party Payer ❑Non-Treatment Provider (i.e. parole, court, school)

Address: _____

Phone#: Fax #:

Patient's Name: _____ Date of Birth: _____

Name at time of treatment: _____ Social Security #: _____

Patient's Address: Phone #:

For Third Parties Requesting SBHI Records, indicate date range of treatment records required: **Begin date**_____ **End date**_____

Only records within date range will be sent. **Charges for records requests may apply.** A new release MUST be completed for each new request.

I authorize the release, sharing and exchanging of my information for the purpose of: (check all that may apply during the time of release)

☐ Coordinating Treatment ☐ Continuity of Care ☐ Gathering Assessment Information for Treatment Planning ☐ Legal

☐ Mental Health/Alcohol & Drug Treatment ☐ Reporting Progress ☐ Patient Request ☐ Other: _____

This information MAY include treatment or rehabilitation for drug and/or alcohol abuse, psychiatric treatment, HIV Antibody Test (test for AIDS Virus) or AIDS and related conditions, IF they did occur. **I specify that this release/exchange is to include:**

☐ Attendance	☐ Treatment Plan - ISP	☐ Lab Results/Reports
☐ Treatment Summary: Mental Health (MH)/Alcohol/Drug (AoD)	☐ Transfer/Discharge Summary	☐ Medical information
☐ MH/AoD Diagnostic Evaluation / Update	☐ Psychiatric Evaluation	☐ Pharmacy/Medication History
☐ MH/AoD Treatment Progress Notes	☐ Pharmacological/Psychiatric Notes	☐ Court records
☐ Occupational Therapy Evaluation &/or Treatment	☐ Medications Prescribed	☐ Consultation
☐ School records / IEP/outcome measures/progress	☐ Crisis Evaluation/Plan	☐ Other:

Information may be shared by mail, fax, phone, in-person, verbally, or via an Approved Health Information Exchange.

Federal confidentially regulations prohibit the recipient of this released information from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. ✦ Substance use disorder records of Part 2 programs disclosed pursuant to this Consent are protected by federal regulations & cannot be re-disclosed without my written consent unless otherwise provided for in the regulations. Any information disclosed pursuant to this Consent other than substance use disorder records or records protected under another state law may be subject to re-disclosure by the recipient. ✦ I might be denied services if I refuse to authorize disclosure of information for purposes of assessment, treatment, or payment relating to substance use disorder if refusal is permitted by state law. My refusal to authorize disclosure of information for other purposes will not affect my ability to obtain treatment or services. ✦ If I have authorized disclosure to a generally described group or class of participants in an entity which is not my treatment provider, upon my written request, I must be provided a list of entities to which my information has been disclosed pursuant to that general designation. **This authorization will remain in effect until revoked or on above expiration date. I understand that I may revoke or cancel this authorization at any time by submitting written revocation, "Revocation of Release Medical Information" form, except to the extent that action has been taken in reliance on this authorization.** *If client is a minor, both client and parent/guardian are asked to sign.*

_____ _____

Signature/Client Date **Name and Signature of Authorized Representative to Individual* Date

Relationship: ❑Parent ❑Legal Guardian ❑POA ❑Other_____

_____ **If the signature is not that of the client/patient, explain, including authority to sign*

Witness Date *on behalf of the client and documentary evidence provided.* SBHI-098 (01-2024)

SBHI Programs and Locations:

Integrated Care Solutions, School Services, YCATS:	▪ Elizabeth Place, 601 Edwin C. Moses Blvd, Dayton, OH 45417	▪ 937 734-8333	▪ Fax: 937 734-8339
SBHI – Atrium:	▪ 401 Atrium Dr., BH Outpatient, Middletown, OH 45005	▪ 513 974-6049	▪ Fax: 937-641-2664
SBHI - CAM:	▪ Elizabeth Place, 601 Edwin C. Moses Blvd, Dayton, OH 45417	▪ 937 734-9810	▪ Fax: 937 734-9830
SBHI – Miami Co. Ofc:	▪ 3031 N. County Road 25-A, Troy, OH 45356	▪ 937 440-7121	▪ Fax: 937 440-7110
SBHI – Preble Co. Ofc:	▪ 225 North Barron Street, Eaton, OH 45320	▪ 937 456-1915	▪ Fax: 937 456-2208
SBHI – Substance Abuse OP:	▪ Elizabeth Place, 601 S Edwin C Moses Blvd, Dayton, OH 45417	▪ 937 734-8333	▪ Fax: 937 734-4999

Samaritan
Behavioral Health

HEALTH HISTORY QUESTIONNAIRE

This form should be completed as fully as possible by client and reviewed by medical staff.

Client Name (Last, First, MI):	**Age:**	**Gender:** ☐ M ☐ F ☐Other Defined	**Today's Date**

Has the client had any of the following Medical Conditions?

Medical Condition	**Yes**	**No**	**Medical Condition**	**Yes**	**No**
Arthritis &/or Bone/Joint Problems	☐	☐	Oral Health/Dental	☐	☐
Asthma	☐	☐	Stomach/Bowel Problems	☐	☐
Bleeding Disorder	☐	☐	Stroke	☐	☐
Blood Pressure (high or low)	☐	☐	Thyroid	☐	☐
Cancer	☐	☐	Tuberculosis	☐	☐
Cirrhosis/Liver Disease / Hepatitis/ Jaundice	☐	☐	AIDS/HIV	☐	☐
Diabetes	☐	☐	Hepatitis C	☐	☐
Epilepsy/Seizures	☐	☐	Sexual Transmitted Disease	☐	☐
Eye Disease/Blindness/Vision Changes/ Glaucoma	☐	☐	Learning Problems	☐	☐
Fibromyalgia/Muscle Pain	☐	☐	Speech Problems	☐	☐
Headaches	☐	☐	Eating /Nutritional Problems	☐	☐
Head Injury/Brain Tumor	☐	☐	Sexual Problems	☐	☐
Hearing Problems/Deafness	☐	☐	Sleep Problems	☐	☐
Heart Disease	☐	☐	Confusion / Memory Problems	☐	☐
Kidney Disease	☐	☐	Other:	☐	☐
Lung Disease	☐	☐	Other:	☐	☐

Please give details of any of the above checked conditions.

Please note family history of any of the above conditions and client's relationship to that family member.

Health Care Utilization

Name of Primary Care Physician: ☐ None Address/Phone:
Date of Last Physical Exam: ☐ Unknown

Pain Screening: Pain Issues? ☐ No ☐ Yes Does pain interfere with your activities? ☐ No ☐ Yes

If yes, how much does it interfere with these activities (please check) ☐ Not at All ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely

Please indicate the source of the pain.

Height/Weight

Height:	If reporting for a child, has height changed in the past year? ☐ No ☐ Yes - by how much (+ or -)?
Weight:	Has client's or child's weight changed in the past year? ☐ No ☐ Yes - by how much (+ or -)?

Allergies/Drug Sensitivities ☐ No Known Allergies to Medications/Drug ☐ No Known Allergies to Other

☐ Medications/Drugs ☐ Food ☐ Insects ☐ Animals ☐ Materials ☐ Other:

Specify Allergen and Reaction:

Past Medications? ☐ Yes ☐ No
If yes, please list:

☐ None Reported

Current Prescription and Over-the-Counter Medications ☐ No Medications ☐ None Reported

Name of Prescription, over-the-counter medication or herbal therapy	Taken for what condition	Dose/ Route/ Frequency	Side Effects?	Is this medication effective?	Assistance needed in taking or managing your medications?	Prescriber
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	
				☐ Yes ☐ No	☐ Yes ☐ No	

Use of any complementary health approaches (Acupuncture, Massage, Meditation, Yoga, etc.)? **Yes** **No**
If yes, please describe:

Use of Assistive Devices (cane, walker, wheelchair, hearing aids, etc.)? **Yes** **No**
If yes, please describe:

At Risk behaviors:

☐ None Indicated	☐ Extreme Sports	☐ Taking meds not prescribed to you	☐ Uncontrolled shopping/ spending
☐ Driving at Excessive Speeds	☐ Needle Sharing	☐ Taking more medication than prescribed	☐ Unprotected Sex
☐ Driving under the influence	☐ Self-Cutting Behavior	☐ Uncontrolled gambling	☐ Other

Immunizations - Has client had or been immunized for the following diseases? Check all applicable or ☐ None/Unknown

☐ Adults: Pneumonia	☐ Chicken Pox	☐ German Measles	☐ Measles	☐ Polio
☐ Age 60+: Shingles	☐ Diphtheria	☐ Hepatitis B	☐ Mumps	☐ Tetanus
☐ Age 65+: Prevnar 13	☐ Flu Shot - within last 12 mos.	☐ COVID	☐ Other	☐ Other

Pregnancy History: Total number of births: _____ Currently Pregnant? ☐ No ☐ Yes, expected due date:
If currently pregnant, stage of pregnancy: ☐ Unsure ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester
Receiving pre-natal healthcare? ☐ No ☐ Yes, Provider: _____ Week Prenatal care began:
Child birth within last 5 years? ☐ No ☐ Yes Are you currently breastfeeding? ☐ No ☐ Yes
Any significant pregnancy history? ☐ No ☐ Yes If yes, explain:

Advance Directive / Living Will: Do you have an Advance Directive/Living Will for medical care or psychiatric care? (If you were unable to make decisions for yourself) ☐ No ☐ Yes If yes, provide details:

Payee/Guardianship Do you have a guardian or payee (adults)? ☐ No ☐ Yes If yes, details:

Name of Person Completing form	**Relationship to Client**	**Date**

Office Use Only: Clinician to review Health History with client and enter into electronic health record. Send as next to sign to Nurse. Nurse's signature on Health History in client's electronic health record denotes completion of Medical Review.

Rev 6-10-2022

Samaritan Behavioral Health, Inc. (SBHI)
HIPAA Communications Consent, Documentation & Client Services Review

SBHI Programs include: ◆Community Care ◆Integrated Care Solutions ◆SBHI-CAM ◆SBHI-Preble ◆SBHI – Atrium ◆Substance Abuse Services ◆School Services ◆YCATS

Date: _____ Client Name: _____ID#: _____

Document Completion Status: ❒ In-Person ❒ Remote w/ADOBE Sign & Verbal Consent
❒ Remote w/Verbal Consent - If Signature Not Obtainable on this Date, Reason & Plan to Obtain:
_____

Client Preferences for Methods of Contact and Communications Consent:

1. New/changed phone #? (*update new info in CL Contact*) Phone Type: ❒ Cell/Mobile ❒ Home ❒ Other _____
   (_____) _____-_____ Primary phone? ❒Yes (*update new info in Contact module)*
2. I consent for SBHI to contact me at my current contact phone number(s), which may include appointment reminders. ❒ Yes ❒ No ❒ N/A ❒ No Response
3. I consent for SBHI to leave a message, voice mail or with anyone who answers ❒ Yes ❒ No ❒ N/A ❒ No Response
4. I consent for SBHI to call my pharmacy ❒ Yes ❒ No ❒ N/A ❒ No Response
   Pharmacy Name _____ Pharmacy Phone ( ) _____ - _____
5. I consent for SBHI to send letters or other notices to my home address ❒ Yes ❒ No ❒ N/A ❒ No Response
6. I consent for SBHI to receive notifications of my hospitalizations ❒ Yes ❒ No, Opt Out ❒ No Response
7. I consent for SBHI to take my picture for my health record ❒ Yes ❒ No, Opt Out ❒ No Response
8. I consent for SBHI to send me TEXT appointment reminders ❒ Yes ❒ No ❒ N/A ❒ No Response

SBHI uses texting in two different ways: *Appointment reminders via text. *Telehealth will require a text link for video visits with your clinician, a separate Consent for Telehealth is also needed.

Client Orientation to Services - Documents Reviewed/Completed with Client/Guardian:

- ✓ Review/Update Client/Guardian Address, Phone, Insurance Information (*Intake/Annual)*
- ✓ Consent to Treat (including notice of enrollment in GOSH system for Board Funding) (*Intake)*
- ✓ HIPAA – Client Preferences for Methods of Contact and Communication *(Intake/Annual)*
- ✓ Welcome Booklet*, including Client Rights, HIPAA Privacy Notice (Intake/Annual)*
- ✓ Safety – Emergency Exits/Shelter, Fire suppression, First Aid kits (*Intake)*
- ✓ Release of Information*,* if applicable. *(Intake/Annual)*

Board Funded Clients:

** Residency Verification (Mont/Preble Co.) ** Subsidy Application/Income (Mont. Co.) **Income Declaration (Preble Co.)

Welcome Booklet Content: *(Intake and Annually)*

** General Info & Assessment of Needs **Treatment, Transition, & Discharge Process
** HIPAA & Exceptions to Privacy ** Informed Consent - Risks, Benefits & Alternatives to Treatment
** Program Rules, (including Attendance, Involuntary Termination, Restraints, Smoking/Tobacco use, Drug use, Handling of Personal Medications, and Weapons)
** Client/Patient Rights and Responsibilities, which includes the Grievance procedure ** Professional Conduct Guidelines
** HIPAA Notice of Privacy Practices, including a Summary of Confidentiality of Alcohol/Drug Abuse Records

Acknowledgement of Receipt and Review of Documents
With my signature below, I acknowledge that the consents indicated above are my preferences for method of contact, photo ID, and communication. As part of my Orientation to Services/Annual Review, the items checked above were reviewed with me. I was given the opportunity to ask questions and have these materials read to me.

_____ _____
Client/Patient Signature Signature Date

_____ _____
Parent/Guardian Printed Name and Signature Signature Date

_____ _____
Staff Witness - Printed Name and Signature Signature Date

Samaritan Behavioral Health

CONSENT FOR TREATMENT AND FINANCIAL AUTHORIZATION FOR SERVICES

Client Name (Last, First, MI): _____ Client ID#: _____ Date:_____

Document Completion Status: ❒ In-Person ❒ Remote-ADOBE Sign & Verbal Consent ❒ Remote-Doxyme Sign & Verbal Consent

If Signature Not Obtainable on this Date, Reason & Plan to Obtain: _____

GENERAL CONSENT FOR TREATMENT

I, the undersigned, am the client/patient (or the duly authorized representative of client/patient) and do hereby voluntarily CONSENT TO & AUTHORIZE behavioral health services from SAMARITAN BEHAVIORAL HEALTH, INC. (SBHI), Behavioral health services available through SBHI may include mental health, addiction services, and integrated primary care. Through the normal course of my SBHI treatment, services will be recommended/offered to me for inclusion in my treatment plan.

This agreement also will serve as the basis for determination of who is responsible for payment for services provided by Samaritan Behavioral Health, Inc. (SBHI) to the client/patient. I understand that all information will be kept confidential consistent with Federal and State laws. Confidential information may be internally shared with SBHI treatment team members and administrators on a need to know basis.

RELEASE OF INFORMATION

I understand my insurance company may need to know about me and the care I receive before it will pay my bill. I AUTHORIZE SAMARITAN BEHAVIORAL HEALTH, INC. TO GIVE ANY INFORMATION ABOUT MY TREATMENT for my Mental Health Condition &/or my Substance Abuse Condition &/or my Medical Condition TO MY INSURANCE COMPANY OR OTHER PAYER FOR ANY VISITS TO DETERMINE WHETHER THEY ARE LIABLE TO PAY MY BILL.

I understand I may be eligible to receive services that are paid or partially paid by public funds. I AUTHORIZE SAMARITAN BEHAVIORAL HEALTH, INC. TO DISCLOSE demographic, billing, and other required information to the Ohio Mental Health and Addiction Services and to the County Behavioral Health Service Board of my county of residence. The purpose of the disclosure authorized herein is to enroll me in the applicable County Behavioral Health Services Plan through either the MACSIS Claims system or the GOSH computer software to determine my eligibility for public funds, pay SAMARITAN BEHAVIORAL HEALTH, INC. for services, and provide required information for state reporting. I understand that if I fail to sign the disclosure statement may result in no availability of authorized public funds to pay for my services.

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 AUTHORIZE each of my SBHI treatment team members to disclose any and all information with respect to my treatment, including all records protected under 42 CFR Part 2, to any other members of my SBHI treatment team for purposes of payment and healthcare operations as set forth in 42 CFR Part 2, including but not limited to, care coordination and/or case management services. I understand that my records may be reviewed by SBHI for quality and compliance purposes.

I understand that I may revoke this consent at any time except to the extent that action has been taken and reliance on it. This consent expires automatically on my discharge date.

FINANCIAL AUTHORIZATION

I AUTHORIZE PAYMENT DIRECTLY TO SAMARITAN BEHAVIORAL HEALTH, INC. of the benefits herein specified and otherwise payable to me but not to exceed the regular charges. **I understand that I am responsible for all charges until the bills are paid in full and for the balance of charges not covered by insurance. I understand that a balance greater than $250 will require a payment plan in addition to payment of current charges. SBHI services will be terminated if payment and/or payment plan has not been made within 30 days.**

MEDICARE PATIENTS ONLY – I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I authorize Samaritan Behavioral Health, Inc. to release to the Social Security Administration and/or Medicare program any information needed for this or a related Medicare claim. If for any reason Medicare (or my insurance company) denies payment, I authorize Samaritan Behavioral Health, Inc. to act on my behalf to appeal for payment.

If I should qualify for partial public funding, I understand I am responsible for the portion of the charge that the County Behavioral Health Service Board does not cover:

SUBSIDY FEE AGREEMENT: If it is determined that I am financially eligible to receive a fee SUBSIDY for the service(s) I may receive, I agree to accept the following responsibilities in exchange for the fee subsidy:

- **I WILL PAY MY PORTION OF THE SERVICE CHARGE AT THE TIME OF EACH VISIT.**
- Samaritan Behavioral Health, Inc. will bill my insurance or the County Behavioral Health Service Board of my resident county as payer of services.
- If my insurance fails to pay all or any part of my claim, I agree to furnish written proof of this rejection to Samaritan Behavioral Health, Inc.
- **I AGREE TO AND ACCEPT RESPONSIBILITY MY PORTION OF _____% OF SBHI SERVICE CHARGES. (This may change, subject to the final approval of your County Behavioral Healthcare Board.)**
- **If subsidy not applicable, indicate insurance type:** ❑ Medicaid ❑ Medicare ❑ Medicaid/Medicare ❑ 100% Client/Pt. Self-Pay ❑ Private insurance – client/pt. will pay required deductibles and co-pays

My signature, or that of my authorized representative, indicates that I have read, understand and agree with the above conditions and have provided accurate information.

_____ _____

Signature of Client/Patient or Authorized Legal Representative or Agent / Date Witness (Signature of SBHI employee) / Date

Samaritan Behavioral Health, Inc. (SBHI)
Informed Consent to Participate in Telehealth Services Provided by SBHI

Client Name (Last, First, MI): _____ ID#: _____ DOB: _____

Consent Date: _____

Consent Type: ❑ Consent to Participate in Telehealth Sessions
❑ Revocation of Previously Signed Consent & Date of Previous Consent: _____

Document Completion Status: ❒ In-Person ❒ Remote w/ADOBE Sign & Verbal Consent

Telehealth is the provision of behavioral health services through interactive videoconferencing.

- I understand that even if I opt out of sending/receiving text messages with my OneFifteen Care Team via the "Clinician Platform", I will receive a text message for each Telehealth session with the link to the session, if I agree to participate in Telehealth.
- I understand that telehealth is a live, two-way interaction between myself and my SBHI provider at a different location using audiovisual telecommunications technology to provide services to me that are normally provided to me in person (medication management, counseling, case management, care coordination, peer support, other Therapy/Services). You will be able to see your provider on a video screen and they can see you.
- I understand that the use of telehealth is voluntary and that I may refuse to participate at any time verbally or in writing. My refusal to participate or decision to stop participating will not affect my right to receive treatment in person from my SBHI provider and will be documented in my electronic health record.
- I understand that the laws that protect privacy and the confidentiality of medical information apply to my telehealth visit with my SBHI provider. Telehealth will be provided through a secure and private videoconference application.
- Prior to receiving services, I will be shown the videoconferencing equipment and the process of telehealth will be explained.
- I understand that if I have an emergency during a scheduled session, I will contact the SBHI Nurse or other SBHI Staff for assistance and will be given crisis assistance.
- I understand that if I experience an equipment failure during a scheduled session, I may contact the SBHI Nurse or Front Desk Staff for assistance, and I will be given the option to continue the session by phone during the scheduled period.
- I understand that my telehealth provider will inform me if there is anyone else in the room during the session.
- I understand that I may not record the audio or video of my telehealth session.
- If I receive telehealth services from my home or other community site, I will inform my telehealth provider if there is anyone else in the room or area during the session. I understand that if I have an urgent or an emergency situation, I will explain my urgent or emergency situation to my telehealth provider, and I will follow my telehealth provider's advice.
- Telehealth may include services provided via telephone when approved by State Authority or Emergency Rule.

I have read this document and have had the opportunity to ask questions. I hereby consent to receiving behavioral health services via telehealth.

_____
Client or Client Representative's Signature **Date of Signature**

If signed by Legal Guardian, Name/Relationship to Client: _____

SBHI Staff Name & Signature as Witness Date of Signature

NOTICE OF PRIVACY PRACTICES

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

The terms of this Notice of Privacy Practices apply to Samaritan Behavioral Health, Inc. (SBHI) operating as a clinically integrated health care arrangement composed of SBHI and all of its locations, physicians, and other licensed professionals seeing and treating clients at these sites. A complete listing of our service locations is available upon request. The members of this clinically integrated health care arrangement will share protected health information of our clients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our clients' protected health information and to provide clients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all protected health information maintained by us. You may receive a copy of any revised notices from the location in which you have received services or a copy may be obtained by mailing a request to the Manager of Quality and Compliance, Elizabeth Place, 4th Floor, 601 Edwin C. Moses Blvd., Dayton, OH 45417.

Uses and Disclosures of Your Protected Health Information

Your Authorization: Except as outlined below, we will not use or disclose your protected health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization. There are certain uses and disclosures of your protected health information for which we will always obtain a prior authorization, and these include:

- **Marketing communications**, ***unless*** the communication is made directly to you in person, is simply a promotional gift of nominal value, is a prescription refill reminder, general health or wellness information, or a communication about health related products or services that we offer or that are directly related to your treatment;
- **Most sales** of your protected health information unless for treatment or payment purposes or as required by law; and
- **Psychotherapy notes** unless otherwise permitted or required by law.

Uses and Disclosures for Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your treatment. For instance, therapists, doctors, nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, test, etc.

Uses and Disclosures for Payment: We will use and disclose your protected health information as necessary for the payment of those health professionals and facilities that have treated you or provided services to you. For instance, we may forward information regarding your diagnosis and treatment to your insurance company to arrange a payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for payment of your bill.

Uses and Disclosures for Health Care Operations: We will use and disclose your protected health information as necessary, and as permitted by law, for our healthcare operations which include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving the clinical treatment and care of our clients. We may also disclose your protected health information to another health care facility, health care professional, or health plan for such things as quality assurance and case management but only if that facility, professional, or plan also has or had a client relationship with you.

Health Information Exchange: We may participate in health information exchanges (HIEs) to facilitate the secure exchange of your electronic health information between and among other health care providers, health plans, and health care clearinghouses that participate in the HIE. In order to provide better treatment and coordination of your health care, we may share and receive your health information for treatment, payment, or other health care operations. Your participation in the HIE is voluntary, and your ability to obtain treatment will not be affected if you choose not to participate. You may opt-out at any time by notifying the SBHI Medical Records Department. However, your choice to opt-out does not affect health information that was disclosed through an HIE prior to the time that you opted out.

Family and Friends Involved in Your Care: With your approval, from time to time we may disclose your protected health information to designated family, friends, and others who are involved in your care, or are involved in payment for your care, in order to facilitate that person's involvement in caring for you or in paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times, it may be necessary for us to provide certain protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Fundraising: We may contact you to donate to a fundraising effort on our behalf. You have the right to "opt-out" of receiving fundraising materials/communications and may do so by calling the Director of Quality and Compliance at (937) 734-8333, identifying yourself and stating that you do not wish to receive future fundraising requests. You may also write to us at Samaritan Behavioral Health, Director of Quality and Compliance, Elizabeth Place, 4th Floor, 601 Edwin C. Moses Blvd., Dayton, OH 45417, together with a statement that you do not wish to receive fundraising materials or marketing communications from us. We will honor your request after the date we receive your direction.

Appointments and Services: We may contact you to provide appointment reminders or test results. You have the right to request, and we will accommodate reasonable requests, to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you would prefer that appointment reminders not be left on voice mail or sent to a particular address, we will accommodate all reasonable requests. You may request such confidential communication in writing by sending your request to the Director of Quality and Compliance, Elizabeth Place, 4th Floor, 601 Edwin C. Moses Blvd., Dayton, OH 45417.

Health Products and Services: We may use your protected health information from time to time to communicate with you about health products and services necessary for your treatment, to advise you of new products and services we offer, and to provide general health and wellness information.

Research: In limited circumstances, we may use and disclose your protected health information for research purposes. For example, a research organization may wish to compare outcomes of all clients that received a particular drug and will need to review a series of medical records. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of client information.

Confidentiality of Alcohol and Drug Abuse Client Records: The confidentiality of alcohol and drug abuse client records maintained by this facility is protected by federal law and regulations. Generally, the facility may not say to a person outside the program that you attend a drug or alcohol program or disclose any information identifying you as an alcohol or drug abuser unless: (1) you consent in writing; (2) the disclosure is allowed by a court order; or (3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Federal law and regulations do not protect information about a crime committed by you either at our facility or against any person who works for the facility or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

Other Uses and Disclosures: We are permitted or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization. We may release your protected health information:

- For any purposes required by law;
- As required by law if we suspect child abuse or neglect; we may also release your protected health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence. The duty to report abuse, including abuse of children, elderly persons and adults with developmental disabilities, supersedes (by law) any requirements of confidentiality. In general, professionals and persons involved in the human services system are required to report abuse if they have reason to believe there is a wound, injury, disability, neglect or emotional condition which reasonably indicates that abuse has occurred.
- When an individual's condition represents an immediate threat to the physical safety of self or others, information may be disclosed for the purpose of preventing danger/harm.
- When an individual represents a substantial and immediate risk of serious physical impairment or injury to himself as manifested by evidence that he is unable to provide for and is not providing for his basic physical needs because of mental illness, information may be disclosed for the purpose of preventing danger/harm.
- An attorney representing the Alcohol, Drug Addiction and Mental Health Services Board (ADAMHS) for Montgomery County (if appropriate) or Preble County (if appropriate) has authority to obtain records of individual clients/patients for whom involuntary commitment (hospitalized against your will) proceedings have been initiated. The ADAMHS Boards are a state-funding source and by law must track such information. Information that may be disclosed under this provision is limited to your treatment, treatment needs, and outcomes for success.
- Information in your treatment file may be subject to an order by the court. At that time, Samaritan Behavioral Health Inc. would obey an order from a court to provide your record.
- The Disability Rights of Ohio has authorization to secure a record of a client/patient when their representation of a client/patient warrants such action.
- Representatives of the ADAMHS Board and the Ohio Department of Mental Health and Addition Services (OMHAS) may gain access to client/patient records for the purpose of evaluating the quality of services. They provide funds for services and by law are permitted to audit information.
- Additional exceptions may occur for the purpose of continuity of care/treatment where information may be shared without your prior permission to other healthcare providers who are, or will be, providing you with care. Other exceptions are related to fiscal billing and auditing, program analysis and authorized research. In each instance, only minimal information will be released to qualified personnel with a legitimate need to know.
- A parent, including a non-custodial parent or legal guardian, has the right to review information in the file pertaining to the child, the child's treatment and disclosures made by the child, unless specified otherwise in a court order.
- A legal guardian of an adult has the right to review information in a file pertaining to that adult.
- For public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- Immunizations records released to a student's school, but only if parents or guardians (or the student if not a minor) agree either orally or in writing;
- To the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer to determine workplace-related illness or injury; in most cases you will receive notice that information is disclosed to your employer;
- If required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- If required to do so by subpoena or discovery request; in most cases you will have notice of such release;
- To law enforcement officials as required by law to report wounds, injuries, and crimes;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange for an organ or tissue donation from you or a transplant for you;
- If, in limited instances, we suspect a serious threat to health and safety;
- As required by armed forces services if you are a member of the military; we may also release your protected health information if necessary for national security or intelligence activities; and
- To workers' compensation agencies if necessary for your workers' compensation benefit determination.

Ohio law requires that we obtain a consent from you in many instances before disclosing the performance or results of an HIV test or diagnoses of AIDS or an AIDS-related condition, before disclosing information about drug or alcohol treatment you have received in a drug or alcohol treatment program, and before disclosing information about mental health services you may have received. For full

information on when such consents may be necessary, you can contact the Manager of Quality and Compliance, Elizabeth Place, 4th Floor, 601 Edwin C. Moses Blvd., Dayton, OH 45417.

Rights That You Have

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We will charge you per page if you request a copy of the information. We will also charge for the postage if you request a mailed copy and will charge for preparing a summary of the requested information if you request such summary. You can obtain a request form from the program where you received services.

You have the right to obtain an electronic copy of your health information that exists in an electronic format, and you may direct that the copy be transmitted directly to an entity or person designated by you, provided that any such designation is clear, conspicuous, and specific with complete name and mailing address or other identifying information. We will charge you a fee for our labor and supplies in preparing your copy of the electronic health information.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. In order to be considered by us, all amendment requests must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If any amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form from the program where you have received services.

Accounting of Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures by us of your protected health information for six years prior to the date of your request. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from the program where you have received services. The first accounting in any 12-month period is free. You will be charged a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request, in writing, restrictions on certain of our uses and disclosures of your protected health information for treatment, payment, or health care operations. A restriction request form can be obtained from the program where you have received services. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing, any agreed-to restriction by sending such notice to the Director of Quality and Compliance, Elizabeth Place, 4th Floor, 601 Edwin C. Moses Blvd., Dayton, OH 45417. We will honor any request to restrict disclosures to your health plan if the information to be disclosed pertains solely to a health care item or service for which SBHI has been paid in full.

Breach Notification: In the unlikely event that there is a breach or unauthorized release of your protected health information, you will receive notice and information on steps you may take to protect yourself from harm.

Complaints: If you believe your privacy rights have been violated, you can file a complaint, in writing, with the SBHI Privacy Rights Officer, Elizabeth Place, 4th Floor, 601 Edwin C. Moses Blvd., Dayton, OH 45417. You may also file a complaint, in writing, within 180 days of a violation of your rights with the Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. There will be no retaliation for filing a complaint.

Acknowledgment of Receipt of Notice: You will be asked to sign an acknowledgment form that you received the Notice of Privacy Practices.

For Further Information: If you have questions or need further assistance regarding this Notice, you may contact the Manager of Quality and Compliance, Elizabeth Place, 4th Floor, 601 Edwin C. Moses Blvd., Dayton, OH 45417. As a client, you have the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

Revised Date: May 2024