WILLOW OAK COMMUNUTY BEHAVIORAL HEALTH CENTER

APPLICATION FOR SERVICES

A photocopy of the applicant's picture ID and insurance card must be submitted with application.

Date: _____

Last Name:	First Name:	Middle Name:
Date of Birth: Age:	SSN: ___-___-____	Gender:
Home Phone:	Business Phone:	Cell/Other:
OK to contact? ☐ Yes ☐ No	OK to Contact? ☐ Yes ☐ No	Ok to Contact? ☐ Yes ☐ No
Home Address:		
City:	County:	State: Zip:
OK to contact? ☐ Yes ☐ No		
Mailing Address:		
City:	County:	State: Zip:
OK to contact? ☐ Yes ☐ No		
Email Address:		OK to contact? ☐ Yes ☐ No
Driver's License #:	List any Allergies:	
Referral Source:	How did you hear about us?	Agencies Requiring Services:
Weight:	Height:	

Race:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White ☐ Multi-Racial ☐ Other

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

Ethnicity: Hispanic/Latino Origin ☐ Yes ☐ No

English Proficiency:
- ☐ Proficient in English
- ☐ Limited – Spanish primary language
- ☐ Limited – Primary language Other

Special Population: *Check all that apply*
- ☐ None ☐ Vision impaired
- ☐ HIV+ ☐ Hearing impaired
- ☐ Pregnant ☐ SSI/Disabled
- ☐ Veteran ☐ IV Drug User

Communication:
- ☐ No Impairment
- ☐ American Sign Language
- ☐ Single Words or Gestures
- ☐ Utilizes Language Technology

# of People in Household

Source of Payment: *Check all that apply*
- ☐ Self-Pay
- ☐ Insurance

If insurance, complete insurance section below

Living Situation:
- ☐ Institutional Care/Nursing Home
- ☐ Psychiatric Residential Facility
- ☐ Private Residence
- ☐ Residential Care
- ☐ Homeless but not in shelter
- ☐ Homeless shelter
- ☐ Jail/Correctional Facility
- ☐ Foster Home
- ☐ Other

Preferences for Treatment:
Please select which format you would prefer for treatment. This format is not guaranteed:
☐ Virtual ☐ In-Person

Primary Insurance Name:	Secondary Insurance Name:
Primary Insurance Group #	Secondary Insurance Group #
Policy #	Policy # ☐
Subscriber Name:	Subscriber Name:
Subscriber SSN: DOB:	Subscriber SSN: DOB:
Pre-Cert Number:	Pre-Cert Number:

Employment Status: ☐ Full Time ☐ Part time ☐ Job Training ☐ Under 18 ☐ Over 64 ☐ Mother/child < 6 ☐ Disabled ☐ No Job

Legal Custody: ☐ DFCS Custody ☐ Other Court Appointed Guardian

Last Name:	First Name:	Middle Name:

Emergency Contact:	Legal Guardian:
Name:	Name:
Address:	Address:
Phone Number:	Phone Number:

Pharmacy:	Primary Care Physician:
Name:	Name:
Address:	Address:
Fax Number:	Fax Number:
Phone Number:	Phone Number:

Representative Payee:

Representative Payee Legal Name:	
Address:	City/State/Zip Code:
Phone Number:	Email Address:

Legal Involvement: *Check all that apply*
☐ Treatment Court ☐ Probate Court ☐ Adult Probation ☐ Juvenile Justice ☐ Jail/Law Enforcement ☐ Adult Criminal Court ☐ Parole ☐ DFCS

Justice System Involvement:
Have you been involved with criminal/juvenile system in past year? ☐ Yes ☐ No
Number of arrests, regardless of offense or outcome, in past 30 days: ____

Probation/Parole Officer's Name and Address:

Education: **School Setting**
☐ Enrolled Mainstream School ☐ Enrolled in Alternative School ☐ Enrolled Psycho-Education Center ☐ Enrolled in Home School ☐ Enrolled in Technical School ☐ Not enrolled in School

Highest Level of Education Completed? ____ **Number Days Absent from School/Work in Past Month:** ____

Please complete this section if the person receiving services is under 18 years old or in foster care

INFORMATION ABOUT: ☐ **NATURAL MOTHER** ☐ **NATURAL FATHER** ☐ **FOSTER MOTHER** ☐ **FOSTER FATHER**

Last Name:	First Name:	Middle Name:
Home Phone:	Business Phone:	Other Phone:
Home Address:		
City:	County:	State: Zip:
Place of Employment:		Occupation:

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

I attest that the information provided is accurate as of the date completed.

_____ _____
Individual Signature Date

WILLOW OAK
COMMUNITY BEHAVIORAL HEALTH CENTER
Phone: 770-683-6946
37 Calumet Parkway, Bldg, J, Ste. 101 & 102, Newnan, GA 30263

Credit Card Authorization

This form is for you to supply Willow Oak Community Behavioral Health Center, Inc. ("Willow Oak") with credit card information to keep on file for the payment of all services and fees, including but not limited to co-pays, no-shows or cancellations outside the parameters as agreed in Willow Oak's co-pay and cancellation policies. A new form must be completed for each card kept on file. Willow Oak accepts Visa, MasterCard, American Express and Discover Card.

Card Information: Card Type (**Circle**): Visa / MasterCard / Discover / AmEx

Name on Card: _____

Card Number: _____

Expiration Date: _____ **CVV Code (Security Code)**: _____

Cardholder Signature: _____

Please list anyone other than the cardholder that is authorized to use this credit card.

Name: _____

Date: _____

Cardholder Signature: _____

**Please accompany this form with a copy of your driver's license or photo ID as well as for any and all parties listed above.

I elect to participate in automatic co-payments utilizing this card, as detailed in Willow Oak's Financial Policy.

☐ **Yes** ☐ **No**

I hereby authorize Willow Oak to charge the credit card listed above for the payment of all applicable services and fees. This credit card will be kept on file and will remain in effect until the expiration of the credit card account. Applicants may revoke this credit card on file by submitting a written request to the address at the top of this form. A new form must be submitted if any information such as credit card expirations or authorized users is amended. Applicants agrees to pay the cost ($35.00) for any returned or challenged payments.

Client Signature: _____

Date: _____

Updated March 2021

Willow Oak Community Behavioral Health Center, Inc.
37 Calumet Parkway, Building J, Suite 101 & 102, Newnan, GA 30263
O: 770-7683-6946 F: 770-683-6949
Willowoakgeorgia.com

Request of Confidential Medical Records

I (Client and/or Legal Guardian) hereby authorize **Willow Oak Community Behavioral Health Center, Inc.** to receive information and medical records about services rendered:

Name, address, medical records fax number of agencies WOCBHC requesting information from:

_____

_____

_____

This information will be used for the following purpose(s): **Behavioral Health Services**

Such information may be transmitted under the conditions stated below and/or required by Federal and/or State law, including court orders. This release is effective for a period of one year from the date of release or by written request of the client.

Dates of services covered in this request: Records within the last 3 years records from today's date

Individual Name: Date of Birth:

Insurance #: Referral Date:

Information to be given may include:

• **Medical Records**	• **Social/Development History**	• **Lab & X-Ray Reports**
• **Discharge Summary**	• **Psychiatric Evaluation**	• **Verified Diagnosis**
• **Psychological Evaluation**	• **Education Records ***	• **Psychiatric Treatment**
• **Vocational Evaluation/Summary**	• **Other Documents/Records**	• **Medication Reconciliation Form**

*Education records may include but are not limited to academic/grade reports, attendance reports, behavioral/discipline reports, student support, behavior plans, special education (IEP, Psycho-education evaluations), standardized test scores, and tribunal records.

Phone Number: _____

_____

Consented Individual's Signature Today's Date

_____

Witness Signature Today's Date

To the agency or person receiving information with this release: This information has been disclosed from records whose confidentiality is protected by state law. State regulations prohibit you from making any further disclosure of this information without prior written consent of the person to who it pertains and/or the parent/legal guardian.

WILLOW OAK COMMUNITY BEHAVIORAL HEALTH CLINIC

INDIVIDUAL RIGHTS

As a participant in our program, you have rights.

1. Having your health and safety protected while in services.
2. Prompt and confidential services in the least restrictive environment available.
3. Being treated with respect and dignity.
4. Receiving treatment without regard to race, sex, or age.
5. Taking part in planning your own treatment and knowing the benefits, risks, and/or side effects of all medications and treatment alternatives.
6. Knowing the cost of your treatment and your responsibility for payment.
7. Being free of restraints or seclusion, except as a last resort for safety.
8. Being free of mental, physical, sexual or verbal abuse and free of neglect or exploitation.
9. Being free of retaliation and humiliation.
10. Pursuing employment, education and religious expression.
11. Seeing or refusing to see visitors; making and receiving telephone calls.
12. Request accommodations for cultural and religious reasons.
13. Accessing free interpretation services as needed and access to information pertinent to treatment which will assist you in your decision making.
14. Consulting your own physician or attorney; filing a complaint. Reporting violations or infringements of your rights without retaliation.
15. Being free from discrimination and retaliation due to any complaint or report made.
16. Receiving a separate Notice of Privacy Practices about confidentiality of your protected health information. Receiving notification of confidentiality of AD Records when applicable.
17. Receiving information regarding how to access your own records.
18. Informed consent and informed refusal to service delivery, release of information, and composition of your treatment team.
19. Access or referral to legal entities for appropriate representation, self help support and advocacy support services.

My signature below signifies that I have reviewed the Individual Rights associated with Willow Oak. I have had an opportunity to ask questions and receive answers. My signature indicates my willingness to proceed with treatment.

_____ _____

Individual Signature **Date**

Printed Name: _____

_____ _____

Willow Oak Representative Signature **Date**

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Http://www.wilowoakgeorgia.com

THERAPEUTIC CONTRACT

Welcome to Willow Oak Community Behavioral Health Center; we look forward to working with you. This document contains important information about our professional services and business policies at Willow Oak Community Behavioral Health Center. Also, you will be expected to read and sign our Health Insurance Portability and Accountability Act (HIPAA) form. HIPAA is a federal law that provides privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. Law also requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. Please note any questions you might have so that we can discuss them.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements as it varies depending on the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit as it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Since therapy often involves discussing unpleasant aspects of your life, you may experience some uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

We usually schedule one appointment hour of 50 minutes duration per week at a time we agree on; although, sessions may be more or less frequent depending on your needs. In order to limit missed appointments, we have implemented a "**No-Show Appointment Fee**" of **$50.00**. We realize that emergencies are inevitable; therefore, late cancellations due to severe illness or family emergencies are excluded from this policy. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. _____

PROFESSIONAL FEES

The standard hourly fee for therapy at Willow Oak Community Behavioral Health Center is $125-135/ hr. In addition to appointments, we charge this amount for other professional services you may need; although, we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone calls lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records for treatment summaries, and the time spent performing any other service you may request of your provider. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time, including preparation and transportation costs. _____

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, Willow Oak Behavioral Health Center has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require us to disclose otherwise

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confidential information. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included. _____

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you are ultimately the party responsible for full payment. It is very important that you find out exactly what mental health services your insurance policy covers. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can. If necessary, we will be willing to call the company on your behalf. You should also be aware that your contract with your health insurance company often requires that your therapist provide them with information relevant to the services that you receive at Willow Oak Behavioral Health Center. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. By signing this Agreement, you agree that we can provide requested information to your carrier. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you have the right to pay for services yourself to avoid the problems described above. _____

CONTACTING YOUR THERAPIST at WILLOW OAK COMMUNITY BEHAVIORAL HEALTH CENTER

Due to our work schedule, your provider may not be immediately available by telephone. Our voicemail system is checked for messages regularly during normal business hours. Messages left on weekends or holidays will be returned the following business day. Occasionally, messages get lost or are not received, so if you have not received an expected return call, you will need to call again. If you are difficult to reach, please inform me of some times when you will be available. Please see the section entitled 'Telemental Health Policies' in regards to using phone and email to communicate.

EMERGENCIES

The practice of private outpatient psychotherapy makes the assumption that clients are functioning, self-responsible individuals with legitimate pain and legitimate needs. Private outpatient psychotherapy cannot, by its structure, assume responsibility for day-to-day functioning of its clients in the same way agencies and institutions can. With this philosophy in mind, we attempt to operate our practice in a way that is responsible to your needs, encouraging of your autonomy, and respectful of our limits. During weekdays, we will make every effort to return phone calls within 24 hours, and weekend calls will be returned by Monday or the first business day after a holiday weekend, barring personal emergency, or planned out-of-town absences. If you feel that you cannot wait for your provider to return your call, please contact your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call. If your therapist is expected to be unavailable for an extended period of time, we will let you know in advance and will, if requested, provide you with the name of a trusted colleague whom you can contact during their absence.

INCLEMENT WEATHER PLAN

In the case of severe weather or a local natural disaster please, call our office for additional information. Updates regarding the status of all appointments will be left on the office voicemail. If the local phone service is not available, it can be assumed that your appointment will need to be rescheduled at a later time. Also, check out our **Face Book page at (WillowOakCommunityBehavioralHealthCenter)** for updates. _____

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CONFIDENTIALITY

With the exception of specific exceptions described in our HIPAA form, you have the absolute right to the confidentiality of your counseling. In general, the law and ethics of the counseling profession protects the confidentiality of all communications between a client and his/her counselor, and the counselor may only release information about the sessions to others with your written permission. We take your confidentiality very seriously and work hard to insure that information is shared only with your consent and awareness. You should know, however, that information might sometimes be shared with other professionals in our agency (supervisors, clinical review team). This is done only when necessary and relevant to your clinical needs. All persons involved in the supervision of interns are fully licensed and bound by the same laws and ethics of confidentiality that your counselor adheres to.

TELEMENTAL HEALTH POLICIES

Per Georgia Composite Board Rule 135-11-.01, therapists must inform clients of the risks and benefits of using technology (phone, email, fax, synchronous video conferencing) to communicate. When using technology there is always the risk of security issues, however technology allows us to connect with people who may otherwise not be able to access services. In order to protect your confidentiality and to facilitate the security of your information as much as possible, the staff at Willow Oak Community Behavioral Health Center will use technology sparingly. In regards to communication with you, emails and phone calls will be limited to scheduling, providing resources, and supplying necessary insurance information. Should you require phone or video conferencing sessions this will be discussed with your personal therapist to determine how best to protect you. Should you send personal information via email, phone, or fax, you do so at your own risk. Unless otherwise discussed, Willow Oak Community Behavioral Health Center staff will not supply therapeutic services outside of those listed above. If you'd like us to connect with other professionals, we will supply ROIs electronically and connect with them via phone. Internally, our staff uses an electronic calendar that provides first names and last name initials. Additionally, we communicate via email and phone to relay messages, as well as verify and submit insurance information. We are happy to discuss this more with you at any time. _____

_____ _____

Signature of Patient (or Legal Guardian) Date

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Informed Consent for Telemental Health Services

The following information is provided to clients who are seeking telemental health therapy. This document covers your rights, risks and benefits associated with receiving services, my policies, and your authorization. Please read this document carefully and note any questions you would like to discuss.

Client's Rights

- You have the right to decide to end our psychotherapy work at any time without prejudice. If you wish, I will provide you with the names of other qualified therapists.
- You have the right to ask any questions about procedures used during therapy. If you wish, I will explain my usual method of psychotherapy practices with you.
- You have the right to refuse the use of any therapeutic technique. I will inform you if I intend to use any unusual procedures and explain any risks involved.
- You have the right to learn about alternative methods of treatment. I will discuss these with you during our work together.
- Telemental health services are not appropriate for all clients. Generally, those who are experiencing suicidal ideation or altered mental status are not appropriate. Should telemental health services not be a good fit for you, I will assist you in finding alternative options.

Benefits and Risks

Telemental health refers to psychotherapy services that occur via phone, email, or synchronous video conferencing. All of our interactions will fall under this term. When using technology there is always the risk of security issues, as well as technical issues (phone not charged, computer or software not working, etc.). You will develop an individualized plan for how best to address technical issues that may arise and will take steps to facilitate the security of interactions with your therapist. In addition to the identified risks, there are several benefits that come from using technology. For instance, it allows therapists to connect with people who may otherwise not be able to access services, there is an opportunity for more flexibility in scheduling, and convenience in being able to connect from a space of your choosing. In order to protect your confidentiality and to facilitate the security of your information as much as possible, here is a list of recommendation

- Engage in sessions in a private location where you cannot be heard by others
- Use a private phone
- Do not record any sessions
- Password protect any technology on which you will be interacting with your therapist
- Always log out or hang up once therapy sessions are completed
- To avoid others knowing we have connected, our therapist will be contacting you from a blocked number

Emergency Management Plan

Willow Oak Community Behavioral Health Center (WOCBHC) does not provide emergency services. In the event of an emergency, it is imperative you are aware of resources in your area. As a precaution, please identify two (2) nearby emergency hospitals below. In addition, you will need to provide information for an emergency contact person. These all need to be filled out to participate in telemental health services.

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Hospital #1: name	
Hospital #1: Address	
Hospital #1: Phone Number	

Hospital #2: Name	
Hospital #2: Address	
Hospital #3: Phone Number	

Emergency Contact Name:	
Emergency Contact Number:	

Contacting Your Therapist

Email is the main form of contact that will be used outside of the consultation and sessions. Please note that email is not secure, so communication should be limited to scheduling questions, providing resources, and supplying any applicable insurance information.

Payment for Services (See Financial Policy & Credit Card Authorization)

Authorization for Treatment

I, _____, authorize evaluation and treatment from

_____ . I acknowledge that I have may request a copy of this informed consent agreement. It is agreed that either of us may discontinue treatment at any time.

_____ _____

Signature Date

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GEORGIA HIPAA NOTICE

Notice of Policies and Practices To Protect the Privacy of Your Health Information in Accordance with The Health Insurance Portability and Accountability Act (HIPAA) and Georgia State Laws.

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION UNDER THE NEW HIPPA LAWS. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and healthcare operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Healthcare Operations" is when I provide, coordinate or manage your healthcare and other services related to your healthcare. An example of treatment would be when I consult with another healthcare provider, such as your family physician or psychologist.
- "Payment" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- "Healthcare Operations" are activities that relate to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or healthcare operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or healthcare operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

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Serious Threat to Health or Safety – If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

- Child Abuse – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
- Adult and Domestic Abuse – If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.
- Health Oversight – If I am the subject of an inquiry by the Georgia Board of Psychological Examiners or the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists, I may be required to disclose protected health information regarding you in proceedings before the Board.
- Judicial or Administrative Proceedings–If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Worker's Compensation– I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's and Counselor's Duties

- Right to Request Restrictions-You have the right to request restrictions on certain uses and Disclosures of protected health information. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations-You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- Right to Inspect and Copy–You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. An appointment will be scheduled to review these records in my presence so that any issues can be discussed. Normal hourly and/or copying changes will apply. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend–You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. Upon your request, I will discuss with you the details of the amendment process.
- Right to an Accounting–You generally have the right to receive an accounting of disclosures of PHI. Upon your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy–You have the right to obtain a paper copy of the notice from me upon request.

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Psychologist's/Counselor's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you at the mailing address you provided.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact us at (770) 683-6946; via email at COMPLIANCE@willowoakgeorgia.com or via U.S. mail at 37 Calumet Parkway, Bldg. J. Suite 101 & 102, Newnan, GA. 30263. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

V. Restrictions

I will limit the uses or disclosures that I will make as follows:

I will not release the contents of "Psychotherapy Notes" under any circumstance with the following exceptions:

- If you file a lawsuit or ethics complaint against me, I may release "Psychotherapy Notes" for use in my defense.
- When the following "Uses and Disclosures when Neither Consent nor Authorization" apply:
  - Child Abuse
  - Adult and Domestic Abuse
  - Health Oversight
  - Judicial or Administrative Proceedings
  - Serious Threat to Health or Safety

Client Information and Consent for Services and the **Georgia HIPPA Notice Signature Page**

I have read, understand, and agree to abide by the terms and conditions set forth in the Client Information and Consent for Services, and do hereby consent to participation in the treatment as described in the consent agreement. I also understand that my participation is entirely voluntary and that I may withdraw my consent and terminate treatment at any time. I have been provided with the Georgia HIPAA Notice and I understand. HIPAA is a federal law that provides privacy protections and assures patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a complete printed copy of the Georgia HIPAA Notice for use and disclosure of PHI for treatment, payment and healthcare operations. The Georgia HIPAA Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. We can discuss any questions that you may have about the procedures outlined in the Georgia HIPAA Notice.

_____ _____

Patient (or Guardian) Signature Date

37 Calumet Parkway, Bldg. J., Suite 101 & 102;
Newnan, Georgia 30263
Office: 770-683-6946 Fax: (770) 683-6949
Http://www.wilowoakgeorgia.com

If you intend on using your health insurance to help pay for treatment, please read and sign the following: I hereby authorize Willow Oak Community Behavioral Health Center, LLC to furnish my insurance company with all the information they request. I also instruct my insurance company to pay my claim directly to Willow Oak Community Behavioral Health Center, LLC where applicable. I understand that if my insurance requires authorization and I choose to receive services before written authorization has been received by Willow Oak Community Behavioral Health Center, LLC, that I will accept financial responsibility for all charges. I understand that authorization is not a

Guarantee of payment. I also understand that even if services are authorized, that if I am not eligible on the date of service, or if it is later determined that my policy does not cover the item(s) I am receiving, I may be responsible for payment in full. I further understand that my insurance company may deduct a co-pay, a percentage, and/or a deductible from their payment to Willow Oak Community Behavioral Health Center, LLC I agree to pay promptly for these amounts.

_____ _____

Insured's Signature or Legal Guardian Date

WILLOW OAK COMMUNITY BEHAVIORAL HEALTH CENTER

CONSENT FOR TREATMENT

Willow Oak Community Behavioral Health Center (WO) is committed to providing affordable but effective treatment services. Acceptance of individual responsibility for recovery includes being able to voluntary participate in treatment. Individual responsibility also includes ensuring our offices have your current contact and insurance information.

TREATMENT

I authorize and consent to Willow Oak staff providing outpatient behavioral health treatment as determined to be medically necessary in their professional judgment. I have been informed of the nature and purpose of the treatment and the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period. I understand that Willow Oak offers a one-time consultation session to review treatment options for up to 15 minutes. If the consult extends beyond 15 minutes, charges will be applied based on costs associated with individual therapy.

MESSAGES OR APPOINTMENT REMINDERS

Messages will be of a non-sensitive nature, such as, appointment reminders.
May we leave a message at your home using the Willow Oak/treatment provider name?
☐ Yes ☐ No
May we leave a message at your work using the Willow Oak/treatment provider name?
☐ Yes ☐ No
May we email a message to you at your identified email address using the Willow Oak email?
☐ Yes ☐ No

HEALTH INFORMATION DISCLOSURES

I understand that as part of treatment, payment or Willow Oak operations, it may become necessary to disclose health information to another entity, e.g. referrals to other health care providers. I consent to such disclosure for these uses as permitted by law. I fully understand the information of this consent.

ADVANCE DIRECTIVES

Advance directives are legal documents that allow you to identify your wishes in the event that you are incapacitated or unable to express wishes for health care and treatments. In this setting, it allows you to express your preferences on where to receive care and what treatments you are willing to undergo. A durable power of attorney for health care is a document that names your health care proxy. Your proxy is someone you trust to make health decisions for you if you are unable to do so.

Do you have an advance directive? ☐ Yes ☐ No
Would you like information on developing an advance directive? ☐ Yes ☐ No

WILLOW OAK COMMUNITY BEHAVIORAL HEALTH CENTER

CONSENT FOR TREATMENT

PSYCHIATRIC TREATMENT

I understand that Willow Oak does not offer Psychiatric Treatment without participating in Therapy Services. You must be a current and active participant with your therapist in order to participate in medication management services/psychiatric treatment. Medication management includes initial prescription medication and medication refills.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with the Willow Oak Notice of Privacy Practices that provides a description of Protected Health Information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this statement. I understand that Willow Oak reserves the right to change its Notice of Privacy Practices that will be effective for health information the agency already has about me, as well as any they receive in the future. Willow Oak will post a current copy of the Notice. I understand that I may obtain a copy of the current Notice in effect upon request. I have read all of the above and understand/ agree to all provisions therein regarding responsibility for payment, permission for treatment and Notice of Privacy Practices.

My signature below signifies that I have reviewed the consent for treatment associated with Willow Oak. I have had an opportunity to ask questions and receive answers. My signature indicates my willingness to proceed with treatment.

_____ _____

Individual Signature **Date**

Printed Name: _____

_____ _____

Willow Oak Representative Signature **Date**

WILLOW OAK COMMUNITY BEHAVIORAL HEALTH CENTER

ONLINE PRIVACY POLICY STATEMENT

Willow Oak Community Behavioral Health Center and all the staff is committed to the privacy and confidentiality of the personal information entrusted to us by everyone who visit this site.

We are a HIPPA compliant organization and all employees are required to pass a background check. We utilize encrypted information systems, password protections and human systems to resist access to personal data. Any information collected by our website or given voluntarily will not be used for profit, exploit or redistribution for any purpose beyond providing services you specifically request. The WOCBHC website may contain links to other sites and we are not responsible for the privacy practices of those organizations. You are encouraged to learn more about the privacy policies of those companies.

Our website's security is confirmed by the SSL certificate. This means that you can rest assured that communications (i.e., credit card or other banking information) between your browser and this site's server are private and secure when the SSL certificate is activated.

Willow Oak Community Behavioral Health Center reserves the right to change our privacy practices and this notice without advanced notice. Should we make any material changes to our privacy practices, we will update our notices and make them available to you. The new notice will apply to all health information in our possession including any information created or received before the revised notice became effective.

Questions or Complaints

If you have any questions or complaints regarding this online Privacy Policy please contact our compliancy officer. You will not be penalized or retaliated against in any way for making a complaint to Willow Oak Community Behavioral Health Center or to the Federal Department of Health and Human Services.

All complaint(s) to Willow Oak must be done in writing. To file a complaint with Willow Oak, contact the Privacy and Compliance Officer via email at COMPLIANCE@WILLOWOAKGEORGIA.COM or by mail; Willow Oak Community Behavioral Health Center, 37 Calumet Parkway, Bldg J. Suite 101 & 102, Newnan Georgia, 30263. 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/

USE OF THIS SITE SIGNIFIES YOUR UNDERSTANDING AND AGREEMENT TO COMPLY WITH THE ENTIRE PRIVACY POLICY.

May 21, 2017

WILLOW OAK
COMMUNITY BEHAVIORAL HEALTH CENTER

FINANCIAL POLICY

As COVID-19 has changed our way of operating and brought opportunities to offer virtual treatment services, Willow Oak has done our best to make things as easy as possible for you to make off-site payments and continue to provide affordable, valued care to the individuals we serve.

Payment is expected prior to the delivery of treatment services through one of the following payment options:

- Private Insurance
- Medicaid
- Medicare
- Visa/Mastercard/American Express/Discover Card

It is your responsibility to notify us of any changes in your insurance coverage. We are responsible for providing you with treatment based on your identified needs. As a result, we will process your insurance claim forms. Your insurance company will make final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility. Past due accounts will be subject to a charge of 2% per month interest and submitted to collections if not paid. You are responsible for all collection costs incurred by the office.

Willow Oak requires a current credit card number and credit card authorization on file with Willow Oak in case of cancellations that are made less than 24 hours in advance or no shows.

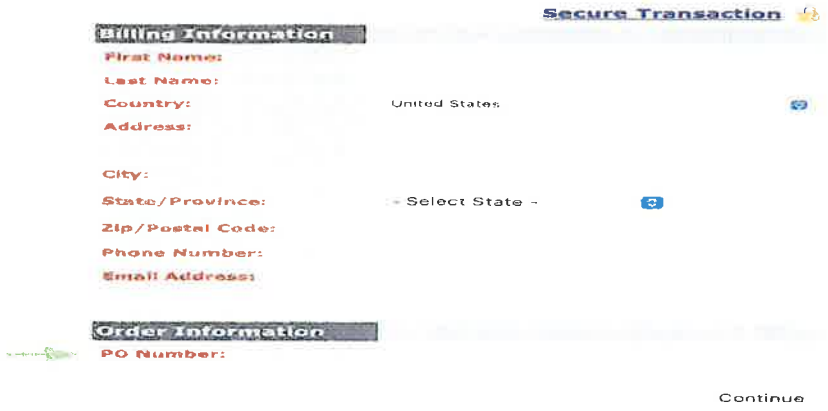
For your convenience, there is also an option to select that this card is automatically charged for your co-pay in advance of your appointment. Payments will be drafted the last operating business day before your appointment Monday – Thursday each week, which may be altered slightly by holidays. If you have questions about a draft date, please call us directly and we will go over this with you. **You must have a credit or debit card on file regardless of your choice to participate in automatic payments.**

If you do not choose the convenience of automatic payments via your authorized card on file, **payments must be made Monday-Thursday by 4pm, no less than 24 hours in advance of your session. Any payments/co-pays for weekend appointments must be made by Thursday at 4pm.** ***If your payment/co-pay is not received by this due date, your appointment will be canceled and your credit card on file will be charged the $50.00 no show/cancellation fee.*** This payment policy will be explained at each reminder phone call.

Your credit card authorization, once completed, can be canceled at any time 72 hours or more prior to your scheduled appointment. This can be done by providing written notice to Willow Oak and must include alternate payment arrangements including an updated Credit Card Authorization form.

Updated March 2021

As always, we continue to offer the convenience of paying through our online payment portal at willowoakgeorgia.com or through contacting the front desk staff (770-683-6946). For payments made through the agency website, select 'Payments' and complete all indicated sections. Your PO number is your first initial and last name.



Once payments are made, your clinician will be notified that you are cleared for participation in the scheduled session.

Willow Oak requires a minimum of 24 hours to change, cancel or reschedule an appointment, with exception to specific individual circumstances. You will be charged a $50.00 missed appointment fee if you fail to cancel, participate in, or reschedule your appointment.

I certify that I have read and agree to Willow Oak's Financial Policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Willow Oak all money to which I am entitled for medical expenses related to the services performed from time to time by Willow Oak, but not to exceed my indebtedness to Willow Oak. I authorize Willow Oak to release any medical information to my insurance carrier or third-party payer, as detailed via Willow Oak's Application for Services, to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency.

_____

Client Printed Name

_____

Parent/Guardian Printed Name (If Client is less than 18 year of age)

_____ _____

Client/Guardian Signature Date

Updated March 2021