Unity Behavioral Health

Informed Consent for Services

I understand that I am eligible to receive a wide range of services through Unity Behavioral Health (Unity) and the services that I may receive will be determined following an applicable assessment or evaluation. The goal of the assessment process is to determine the best course of treatment and I understand that treatment is a collaborative effort being guided by a Treatment Plan, Individualized Service Plan (ISP) or a Person-Centered Plan.

I hereby consent to Unity to provide treatment for me, my minor child(ren), and/or ward which may include but is not limited to various therapies, medical interventions, case management, auxiliary, nursing, transportation and/or other services determined to be medically necessary. The risks and benefits of treatment have been explained to me and I understand that Unity is exempt from any liability.

I understand that services may be provided by a range of healthcare professionals, including some in training which are under the supervision of qualified staff. Some staff may be working under supervision of a licensed professional to perform the duties and functions of behavioral health services. The supervisor is legally responsible for ensuring that effective and ethical quality care is received. I understand that I may ask to meet with my treatment provider's supervisor at any time.

I also understand that clinical records may be reviewed for quality/compliance purposes by Unity staff and/or in clinical supervision to ensure quality treatment. Information necessary to carry out treatment, payment, and healthcare operations will be submitted to appropriate organizations for accreditations, certification or authorizations. Additionally, if I apply for all or part of my treatment to be funded by various third parties other than Medicaid or Commercial Insurance, then I understand and agree that information necessary to carry out treatment, payment, and health care operations will be submitted to those various third parties funding my treatment services.

I acknowledge that the Client Handbook (which includes, but not limited to, Grievance Procedures, Client Rights, Notice of Privacy Practices, etc.) have been provided to me. If Unity's Notice of Privacy Practices should change, I will be notified of the change by receipt of the new Notice of Privacy Practices which will also be posted at all Unity locations. I understand that I may ask questions about those documents prior to and throughout the course of treatment.

To provide treatment, Unity is required to obtain consent for treatment from the individual or minor's legal guardian/custodian. By signing below, I am attesting that I am legally the individual served or the guardian/custodian responsible for the minor named below and am consenting to the services and information provided in this document.

___________________________________ ___________________________________ ____________

Client Name Signature of Parent/Guardian Date

Relationship of signature if other than client: ____

You have the right, at any point, to refuse or withdrawal from treatment. If you choose to refuse or withdrawal consent, Unity staff will, with your approval, offer assistance in developing alternative approaches to ensure you and/or your minor child(ren) receive the needed/recommended services. Please provide any refusals or withdrawals in writing. Unity will document your request to refuse/withdrawal consent in the client record.

Unity Behavioral Health

Financial Agreement and Payment Authorization

This document will serve as the basis for the payment agreement between the individual served and/or the indicated responsible party and Unity Behavioral Health (Unity) for services rendered on behalf of the above individual served.

1. It is understood that fees are charged for all services rendered by Unity. Fees are subject to change and any increase or decrease will be passed on to the individual and third-party payers. Unity will furnish you at any time, upon request, a listing of the current fees for services.

2. Based on the financial information obtained from you, Unity will first bill any insurance/third-party payers you have indicated for the total fee for services. If your insurance/third-party payer does not pay the full amount of the charges, you may be responsible for the remaining amount (contingent on any signed agreements or contracts). If desired, Unity will provide you with an estimated summary of out-of-pocket costs for your insurance coverage. This summary will be based upon an estimate from your insurance company of the benefits available and should not be regarded as a guarantee of payment.

3. Balances remaining after all appropriate third-party payers have been utilized will be your personal obligation. Services rejected by your insurer due to your failure to provide and/or secure needed documentation and information such as Coordination of Benefit information and physician referrals.

4. You must report to Unity immediately, and prior to subsequent visits, report any changes in insurance coverage, including termination, that affects dates on which you received or will receive services. Unity will, upon request, supply you with an updated estimate of out-of-pocket costs upon notification of a coverage change. Any charges denied due to termination and/or failure to provide notification of such change are your personal obligation.

5. By signing below, you verify that the insurance/third-party payer information supplied is true and accurate to the best of your understanding. You also authorize Unity to release appropriate third-party payers' information regarding treatment and services provided that may be necessary for the evaluation and payment of claims made. Finally, you authorize that payment of these benefits be made directly to Unity. You understand that if your insurance company is not timely in paying Unity directly, it is your responsibility to keep your account current while awaiting payment.

6. For returned checks, Unity will pass on any returned check fees assessed. A $35 NSF (Non-Sufficient Funds) charge is applied to balance owed.

7. Payment for copays, deductibles, and non-covered services, is expected at each visit. Failure to pay for services may call for your services being terminated and any other appropriate actions. For your convenience we accept debit cards, credit cards, cash and personal checks.

Name of Individual Responsible: ____ Date: _______________

Signature of Individual Responsible for Fee: _______________________________________

Social Security Number: ___________________________ Relationship: _____________________

Unity Behavioral Health

Consent for Electronic Communication

Unity Behavioral Health (Unity) offers electronic communication options in an effort to remove access to care barriers and expedite service delivery. In order to engage in electronic communication with Unity, I understand and consent to the following:

- I understand that federal and Ohio laws protecting the privacy and confidentiality of client information apply to electronic communication of that information. Unity has made reasonable and appropriate efforts to eliminate any confidentiality risks associated with the use of electronic communications and will comply with all applicable laws, rules, and regulations related to privacy and confidentiality of protected health information, including HIPAA, HITECH, and 42 C.F.R., Part 2.
- I understand that despite reasonable and compliant efforts to protect the privacy and security of electronic communication transmitted or received by Unity, it is not possible to completely guarantee confidentiality and that there are potential privacy risks that I might encounter, including but not limited to: a) People in my home or other environments may access my phone, computer or other devices that I use to communicate with Unity. b) Loss of my cellular phone, computer, or other devices. c) Email accounts being hacked or mis-delivery of an email to an incorrectly typed address. d) Third parties on the Internet such as server administrators who monitor Internet traffic might intercept my communication. e) Electronic communication can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of myself or Unity. f) Any additional risks that may be a result of unsecured Internet and/or email use.
- I understand that electronic communication can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- I understand that electronic communication may be disclosed in accordance with applicable mandated reporting requirements under the law.
- I understand that electronic communication can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.
- I understand that electronic communication is not an appropriate substitute for in-person or over-the-telephone communication with providers.
- I understand that Unity is not responsible for information loss due to technical failures associated with my software or internet service provider.
- I understand that I have the right to revoke my consent for electronic communication and that it is my responsibility to notify Unity if I no longer want to engage in electronic communication.

By signing this document, I acknowledge that I have read the above, understand the potential risks and am consenting to engage in electronic communication with Unity. I also acknowledge that I consent to the use of my electronic signature on applicable documents for the purpose of service delivered by Unity.

☐ I consent to receive the following ☐ I do not consent to electronic communication

_________________________ ____________________________________ ______________

Client Name Signature of Parent/Guardian Date

Relationship of signature if other than client: ____

Telehealth Informed Consent Form

Effective Date: 6/1/24	Applies To: Clients
Rule/Accreditation Ref: CARF 2B	Policy/Procedure Ref:

If, during the course of service delivery with Unity Behavioral Health (Unity), telehealth services are recommended as a mode of receiving healthcare services by my provider, I consent to engage in such telehealth services. I understand that telehealth may include evaluation, assessment, consultation, treatment planning, and the delivery of healthcare treatment services. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications in compliance with all applicable laws, standards, or regulations as are applicable at the time of delivery.

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

- I have the right to withhold or end consent at any time without affecting my right to receive other or future care or treatment.
- The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions will be held in confidence and not released unless otherwise mandated or allowed by law.
- I understand that despite the benefits that may be present from the receipt of telehealth services, there may also be risks related to receiving services via telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Unity, that:
- Telehealth-based services and care may not be as complete as in-person services. Note: I understand that if my provider believes I would be better served by other interventions I will be referred to a provider who may provide those services.
- There may be risks to my privacy or confidentiality based on the location where I choose to receive telehealth services and technology/ internet/ phone security which are outside the control of Unity. I agree that I am aware of these potential issues and will not hold Unity or its staff liable for the actions of persons or companies outside of Unity's control.
- There may be risks to my health if I am in a crisis or emergency and Unity's intervention in such a situation will be limited to coordination of crisis stabilization, including with local emergency or crisis responders. I understand that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threating or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.
- I understand I have the right to access copies of my protected health information in accordance with applicable laws, standards, regulations, and Unity's policies and procedures.
- I understand that I will be required to verify my identity and physical location at each telehealth session. The provider will also verify their identity and any other providers or individual's in either location will be required to verify their identities as well.

I have read and understand the information provided above. I have had the opportunity to discuss these points and any questions or concerns have been addressed.

_____________________________ ____ ____________________

Client Name Signature of Parent/Guardian Date

Relationship of signature if other than client: ____________________________

Unity Behavioral Health

Client Orientation Checklist

The following documents are provided and discussed with each client at their initial assessment and ongoing when appropriate

Document	Client Initials
Informed Consent	
Notice of Privacy Practices	
Client Rights and Responsibilities	
Client Grievances	
Financial Agreement	
Electronic and Telehealth Communications	
Release of Information	
Building and Emergency Procedures	
Technology	
Health and Safety	
Client Feedback	
Discharge Criteria	
Client Handbook	

Provider Name/Signature/Date:

Client Name/Signature/Date: