## Consent for Treatment

I, the undersigned, herby request services from Legacy Behavioral Health Services (LBHS). I understand I have a responsibility to work jointly with my case manager/therapist/medical provider to develop an Individualized Recovery Plan as to treatment involved in my individual case. I consent to allow my records to be utilized by LBHS's staff as needed. I understand all treatment centers of LBHS are included under HIPAA and information can be shared and/or disclosed with other centers to include private psychiatric hospitals, medical hospitals, and State of Georgia Psychiatric facilities without consent pursuant to the terms and conditions of LBHS's Notice of Privacy Practices and applicable laws and regulations. I understand it is required by the Department of Behavioral Health and Developmental Disabilities to report certain critical incidents including the death of any current individual to DBHDD. I understand information regarding my diagnosis and treatment may be collected and shared with my payor sources (s) and/or LBHS's regulatory agencies. I understand my photograph will be part of my electronic medical record. I understand I will receive automated appointment reminds via phone call or text messages. I understand I will be contacted during regular business hours as well as after hours, weekend and/or holidays regarding any critical lab values. I understand LBHS's nursing staff will make three attempts to contact me at the phone number listed in my chart. I also understand failure to be notified in a timely manner may result in a life-threatening situation and I am completely responsible for ensuring my contact information remains current. I understand Advanced Directives will be offered to me.

I hereby authorize LBHS, and the medical providers involved in my care during this period of illness or treatment to take all necessary steps without limitations, to take forth any clinical or administrative appeals on my behalf and all other similar procedures, and further agree to provide and sign any other documents that may be reasonably necessary to accomplish this purpose.

I understand that the person who provides my counseling and is responsible for my case management may be enrolled in a graduate level program or is a graduate level clinician in training or as associate level professional. I understand this professional is practicing under the supervision of a qualified licensed professional and that my case may be recorded, discussed, and reviewed for the purpose of professional development for the clinician. If this professional is a clinician in training, an LAPC, and LMSW, or an LAMFT who are unable to practice independently and require ongoing supervision in order to practice, I am giving my consent to be treated by this person.

I understand that LBHS uses Advanced Practice Nurse Practitioners in each of our treatment settings. I also understand that these APRN's have delegating and designating agreements with licensed physicians pursuant to the requirements of the State Board of Medicine and the State Board of Nursing.

I understand that if I am mandated to services I must know and follow all requirements of the mandate. I further understand that if I do not attend services as scheduled staff will be forced to report to the mandating body.

Incorporating random and target urine drug testing (UDT) as a part of your overall treatment has significant therapeutic utility. UDT is useful tool to make needed alterations to your treatment plan as well as get the confirmation of the state of abstinence. I understand that during my treatment, I may be asked to submit to urine drug screening. LBHS is sometimes asked to share test results with outside entities, such as social services agencies or the criminal justice system. I

understand that providers will ensure that I have given informed consent for sharing test results before they are released to any outside entity. I understand that any positive screenings will be verified by a laboratory test before reporting to an outside entity. I also understand that I may request a laboratory verified drug screen result for my own benefit. I understand that I am responsible for all fees related to UDT.

I understand that Legacy Behavioral Health Services uses telehealth to provide services. I hereby consent to engaging in telemedicine with Legacy Behavioral Health Services (LBHS) as part of my treatment. I understand that I am responsible for any services not covered or paid by my insurance, Medicare, or Medicaid. I further understand that services not paid include copayments and deductibles.

I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to telehealth:
1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. I understand that this withdrawal may cause a delay in my appointment as well as my prescriptions.
2. I understand that all confidentiality protection applies to telehealth. I also understand that my protected health information is private and confidential to the extent permitted by law.
3. I consent for my physician or his/her representative to make use of the assistance of other clinicians and facility staff and may permit them to order or perform all or part of the assessment and that he/she may permit them to have the same discretion in my assessment as him/herself.
4. I understand that if my physician or nurse practitioner or clinician believes I would be better served by another form of treatment or services (e.g., face-to-face services) I will be referred to a provider who can meet my need.
5. I understand that I have a right to access my medical information and copies of medical records in accordance with Georgia law.
6. I understand that I will be asked to verify my identity and location before my provider/clinician will begin my session and that it is my responsibility to unsure that I am in a private location for my telehealth session.
7. I understand that I will be oriented to the use of telehealth equipment.

- I have read and understand the information provided above and have received a copy.
- I have had an opportunity to discuss it with staff and all of my questions have been answered to my satisfaction.

## Legacy Behavioral Health Services NOTICE OF PRIVACY PRACTICES (HIPAA)

### *THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

**Introduction**

This notice of Privacy Practices, effective February 1, 2021, describes how we may use and disclose medical information about you, referred to in this notice as protected Health information (PHI). This notice also describes your rights and certain obligations we have regarding the use and disclosure of PHI and a brief description of how you may exercise these rights.

We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to PHI. We are also required to comply with the terms described in the notice currently in effect. We will post a copy of our Notice at each Legacy Behavioral Health Services site and on our website.

**How We May use and Disclose medical Information About You**

We may use and disclose your PHI as described in each category listed below without obtaining written authorization from you.

**For Treatment.** We will use and disclose your PHI to provide and coordinate your health care, and any related services, including the disclosure of PHI for treatment activities of anther health care provider. In addition, we may disclose your PHI without authorization to another health care provider (EMS, your primary care physician, or a laboratory) working outside of LBHS for purposes of your treatment.

**For Payment.** We will use and disclose your PHI in order to bill and collect payment for treatment and services provided to you. We may also disclose PHI to our business associates, such as billing companies and others that assist in processing health claims. We may also disclose PHI to other health care providers and health plans for payment activities of such providers or health plans.

**For Health Care Operations.** We may use and disclose PHI about you for our health care operations. These uses and disclosures are necessary to run our organization and make sure that our consumers receive quality care. These activities may include, quality assessment and improvement, reviewing the performance or qualifications of our clinicians, training students in clinical activities, and compliance and risk management activities.

**Research.** We may disclose your health information to researchers when their research has been approved by the at DBHDD Institutional Review Board.

**As Required by Law and Law Enforcement.** We will disclose PHI about you when required to do so by applicable law or when ordered to do so in a judicial or administrative proceeding.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI about you to law enforcement personnel or other appropriate persons when necessary to prevent serious and imminent threat to your health or safety or to the health or safety of the pubic or another person.

**Incidental Disclosures.** Some treatment occurs in an open setting. For example, some treatment may be offered as group counseling or group education sessions. Disclosures that occur in such treatment settings are permitted without individual authorization.

**Public health activities.** We may disclose PHI about you as necessary for public health activities including disclosures to report to public health authorities for the purpose of preventing or controlling disease injury or disability; reporting abuse and neglect as required by law; reactions to medications or product defects or problems.

**Natural Disasters:** We may disclose PHI about you in the event of a natural disaster to assist in disaster relief and ensure that the proper medical care is received.

**Health Oversight Activities.** We may disclose PHI about you to a health oversight agency for activities authorized by law.

**Coroners, Medical Examiners or Funeral Directors.** We may provide PHI about a deceased consumer to coroners, medical examiners, and funeral directors for the purpose of identifying deceased persons, to determine the cause of death in certain circumstances or as otherwise necessary for these parties to carry out their duties consistent with applicable law.

**Military and Veterans.** If you are a member of the armed forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI for the purpose of determining your eligibility for benefits provided by the Department of Veterans Affairs.

**National Security and Protective Services for the President and Others.** We may disclose PHI about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI about you to the correctional institutional or law enforcement official for treatment, payment or for the protection of the health and safety of you or others or for the safety and security of the correctional institution.

**Workers Compensation.** We any disclose PHI about you to comply with the state Workers' Compensation law or similar laws.

**Appointment Reminders, Health-related Benefits and Services, Marketing**. We may use and disclose your PHI to contact you and remind you of an appointment at LBHS, or to inform you of treatment alternatives or other health related benefits and services that may be of interest to you.

**Disclosure to you or for HIPAA Compliance Investigations**. We must disclose your PHI to the Secretary of the United States Department of Health and Human Services when requested in order to investigate LBHS's compliance with federal privacy regulations.

**Disclosures to Individuals Involved in your Healthcare or Payment for your Healthcare.** Unless you object, we may disclose your PHI to a family member, other relative, friend, or other person you identify as involved in your healthcare or payment for your health care. We may

also notify these people about your location or condition.

**Uses and Disclosures of Your Health Information with Your Permission.**

Uses and disclosures not described in Section II of this Notice of Privacy Practices will generally only be made with your written permission, called an "authorization." You have the right to revoke an authorization in writing at any time. If you revoke your authorization, we will not make any further uses or disclosures of your PHI under that authorization unless we have already taken an action relaying upon the uses of disclosures you have previously authorized.

**Your Rights Regarding Your Health Information**

**Right to Inspect and Copy.** You have the right to request an opportunity to inspect or copy your PHI that we retain and use to make decisions about your care whether they are decisions about your treatment or payment of your care. You must submit your request in writing to our Privacy Officer. If you request a copy of the information, we may charge a fee for the cost of copying or collecting information per your request. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. If you prefer, we will prepare a summary or an explanation of your health information for a fee. We may deny your request to inspect or copy your PHI if the treating physician determines that disclosure would be detrimental to your physical or mental health. If we deny access to your PHI, we will explain the basis of denial and your opportunity to have your request and the denial reviewed by a licensed health care professional designated as a reviewing official.

**Right to Amend.** If you believe that your PHI maintained by us is inaccurate or incomplete you may ask us to correct your PHI. Your amendment must be written or typed on a separate sheet of paper and specify why you believe the information is inaccurate or incorrect. You may contact the Privacy Office using the information listed at the end of this Notice. If your request if denied, we will provide you a written denial that explains the reason for the denial and your rights.

**Right to an Accounting of Disclosures.** You have the right to request and receive a list of disclosures we have made of your PHI we have made at any time during the last six (6) years prior to the date of the request. The list will not include disclosures made at your request, with your authorization, and dose not includes uses and disclosure to which this notice already applies. To request an accounting of disclosures you must submit your request in writing to the Privacy Officer. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

**Right to Request Restrictions.** You have the right to request that we restrict the use or disclosure of you PHI. We are not required to agree to a restriction but if we do, we will abide by your agreement unless it is needed to provide you with emergency treatment.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about your care only by a particular means or at particular locations. You must make the request in writing. You must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

**Right to a Paper Copy of This Notice.** You have a right to obtain a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically or on our website, you may still obtain a paper copy.

**Confidentiality of Substance Abuse Records**

For individuals who have received treatment, diagnosis, or referral for treatment for a drug or alcohol abuse program, federal law and regulations protect the confidentiality of drug or alcohol abuse treatment records. As a general rule, we may not disclose to a person outside the program that you attend any of these programs, or disclose any information identifying you as an alcohol or drug abuser, unless you authorize the disclosure in writing; the disclosure is authorized by an appropriate court order; the disclosure is made to medical personnel in a medical emergency, to qualified personnel for research, audit or program evaluation purposes, or if you threaten to commit a crime either at a drug abuse or alcohol program or against any person who works for our drug abuse or alcohol programs. Federal law and regulations governing confidentiality of drug or alcohol abuse permit us to report suspected child abuse or neglect under state law to appropriate state or local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 and 42 CFR Part 2)

**Questions and complaints**

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have communication with you by alternative means or at alternative location, you may share your concerns with us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer:

Legacy Behavioral Health Services Privacy Officer-Marcy Crews

Telephone: (229) 424-3139 Fax: (229) 671-6775

E-mail: mcrews@bhsga.com

Address: 3120 N. Oak Street Extension Suite C, Valdosta, GA 3160

## Release of Information

I understand this authorization, except for action already taken, may be revoked by me at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to LBHS. Unless otherwise revoked, this authorization will expire one year from today's date and must post-date any date of service being requested. This authorization becomes null and void from the date entered in the chart that the chart will be closed.

I understand that LBHS will not condition treatment, payment, enrollment, or eligibility for benefits concerning my health care on whether I sign or refuse to sign this authorization.

I understand authorizing the disclosure of this health information is voluntary and disclosure of such information carries with it the potential for unauthorized re-disclosure.

## Financial Policy

It is the policy of Legacy Behavioral Health Services (LBHS) to accurately invoice individuals and third-party payers for assessed fees, co-payments, and deductibles in accordance with all laws and policies as outlined in the Department of Behavioral Health and Developmental Disability Provider Manual (DBHDD), Center of Medicare & Medicaid Services Guidelines (CMS), and third-party insurance provider contracts. It is the policy of LBHS to assist individuals without benefit with making application for health benefit entitlement. It is the policy of LBHS to refer individual accounts to a collection agency if efforts to collect outstanding balances have not been successful.

**INDIGENT CARE**
Before services will be provided, all individuals must complete initial intake documents. During the intake process, individuals are asked to provide demographic information, copy of insurance cards and financial information (such as tax return, W-2, check stub, Medicaid documents, written statement, etc.), as well as verification of family size. However, this will not be a barrier to receiving services that do not require proof of income (DUI classes, other out of pocket services).
Legacy Behavioral Health Services abides by the Sliding Fee Scale Policies provided in the DBHDD provider manual and determines each indigent individual's eligibility for discounts according to the financial documents provided. Legacy Behavioral Health Services must not apply discounts to an indigent individual's account without appropriate financial information and the individual will be charged full fees. Individuals who qualify for the Sliding Fee Scale discount are eligible for one year from the date of qualification. At that time the individual will present current financial information in order to maintain qualification for the Sliding Fee Scale. Any balance remaining after the Sliding Fee Scale discount has been applied to an individual's account, is the responsibility of each individual.

**INDIVIDUALS WITH INSURANCE**
Individuals with third party coverage will be informed prior to rendering services of their liability for copay, deductibles, or service fees not covered or partially covered by the third-party payor. Individuals will receive an account statement at the time of check-in. If the individual disputes the accuracy of the invoice, the secretarial staff or billing department will attempt to resolve the disputed balances with the individual by telephone or in person. Individuals with third party insurance are not eligible for the Sliding Fee Scale discount.

Individuals must present their current insurance card at each visit. Failure to do so may result in the denial of service.

Currently we accept the following insurance:
●Medicaid

●Medicare Part B

●WellCare Medicaid (CMO)

●Peach State Medicaid (CMO)

- Amerigroup Medicaid (CMO)
- CareSource Medicaid (CMO)
- Commercial – (plan must be verified for benefit level & Network status)
- Medicare Advantage Plans – (plan must be verified for benefit level & Network status)

**FEES FOR SERVICES**

Payment is due at the time of service. Your fees were determined at your intake appointment and are reviewed regularly. You can bring in your proof of income (or lack of income) within 2 weeks. If we do not get this information, you will be charged the full fees. Any time your insurance and/or income changes you will need to inform the Front Desk staff.

All fees for services cannot be determined at the Intake appointment. It will depend on the service provider's level/credentials, the service, and the duration of the service. To qualify for State assistance, the member's financial information must be obtained and entered into the system to determine if they qualify for State assistance via the sliding fee scale, possibly at a percentage. Not all services will qualify for the sliding fee scale such as some non-covered State services, Self-Pay only services (certain groups, assessments, or Lab fees), which are the direct responsibility of the consumer. Lab and other misc. manual charges (such as 902) that consumer may have need to be reviewed.

**AUTHORIZATION FOR SERVICES**

In order for your insurance or State to pay for your services we must obtain an authorization. This includes meeting with you to obtain the needed information. An initial authorization will be requested at intake and within the first month of treatment. After that your authorization will be in place for up to one (1) year depending on the services you receive. ***If your authorization lapses you may not be able to receive any other services, including seeing the doctor, until the authorization has been completed.***

Not all services require prior authorization. It depends on the type of coverage the individual has and the service. Traditional Medicaid and State services require a prior authorization via the Georgia Collaborative-ASO that should be completed at intake and concurrently as needed for all services. Initial requests are valid for 90 days, where most concurrent requests are typically approved up to a year, but not all as it is dependent on the type of care requested. CMOs require prior authorization for some, but not all services. CMO approvals can range from 1-3 months, dependent on the CMO determination, if

approved. Some Commercial plans require prior authorizations, but it is dependent on the specific benefit plan.

**COLLECTION AGENCY**
LBHS will make several attempts to collect outstanding balances from individuals. However, if no payment is received in a 90-day period, LBHS reserves the right to send past due accounts to a collection agency.

**RETURNED CHECK FEE**
There is a $35.00 fee for each returned check.

**LABORATORY FEES**
All individuals enrolled in substance use disorders services or are receiving medications have to undergo laboratory testing time to time ~~services~~. ~~Lab~~ Fees associated with laboratory tests are not covered under the Sliding Fee Scale and therefore are the responsibility of the individual for the full amount at the time services are rendered.

If you are covered through a third-party insurance, your insurance information will be provided to cover those fees. Any fees not covered by your insurance will be your responsibility.
Urine drug screens are required for all individuals receiving substance use disorder services and may be ordered by the physician at any time for all persons served by LBHS. You are responsible for the cost of urine drug screens as well.

I have been explained the LBHS financial policies and understand and acknowledge that I am responsible for any service charges not covered by my insurance, non-reimbursable services, or fees assessed to me according to the Sliding Fee Scale.

**PHARMACY FEES**
I understand that LBHS also provides pharmacy services. I understand that if I have a third-party insurance, the pharmacy will bill your insurance company for your medications. Co-pays for medications not covered by your insurance will be your responsibility and should be paid at the time that you pick up the medications.

## Individual Rights

Services to individuals must be given without discrimination based on political affiliation, religion, race, color, sex, mental or physical handicap, national origin, or age. Individuals have many rights and responsibilities.

I have the right to reasonable access to care, regardless of race, religion, sex, sexual orientation, national origin, age, disability, or ability to pay.
I have the right to considerate and respectful care with recognition of my personal dignity, values, and beliefs.
I have the right to be informed of any of the organization's rules and regulations that may apply to me.
I have the right to receive information to assist me in participating in and making decisions about my care. If I am a minor, my parents or guardians have the right to receive information and participate in making decisions about my care.
I have the right to individualized, humane, and quality services in the least restrictive setting, regardless of my ability to pay. There will be a plan for these services, based on my needs, reviewed periodically, and implemented by qualified and competent service providers.
I have the right to participate in the consideration of any ethical issues that may arise during my care.
I have the right to personal privacy and that information will be kept confidential. I understand that there are certain conditions under which information may be released without my consent. These include but are not limited to: (1) Court Orders, (2) Health Emergency, (3) Threatened harm to self or others, (4) Physical or Sexual Abuse as required of a mandatory reporter. I have the right to receive a copy of the Notice of Privacy Practices of Legacy Behavioral Health Services, wherein these rights are described.
I have the right to have someone act as my representative and make decisions on my behalf if I am unable to do so.
I have the right to receive information in a manner and language that I can understand.
I have the right to receive information and education about my needs for service.
I have the right to receive services that protect my health and safety.
I have the right to refuse any service, treatment, or medication to the extent permitted by law.
I have the right to review my records and may request copies of my record.
I have the right to exercise all civil, political, personal and property rights to which I am entitled as a citizen.
I have the right to remain free from physical restraint or seclusion unless an emergency requires such.
I have the right to remain free of neglect and physical or verbal abuse.
I have the right to private conversation, reasonable access to a telephone, uncensored mail, and visitors.
I have the right to keep my personal belongings and money with me.
I have the right to file a complaint with no fear of harassment or retaliation.
I have the right to request a copy of the most recently issued report by Department of Community Health.

## Individual's Responsibilities

I have the responsibility to share pertinent information with my service providers.
I have the responsibility to be considerate and respectful of others.
I have the responsibility to share personal values and beliefs that need consideration.
I have the responsibility to abide by any rules and regulations that may apply to me.
I have the responsibility to participate in and make decisions about my care.
I have the responsibility to adhere to my treatment plan and recommended services. I understand if I do not adhere to my treatment plan and recommended services, I may be discharged from receiving services.
I have the responsibility to participate in the development of my service plan and all aspects of services received.
I have the responsibility to notify my service provider of any ethical issues that arise.
I have the responsibility to understand that all information regarding me is kept confidential unless I sign a release of information.
I have the responsibility to designate a representative decision-maker as needed.
I have the responsibility to notify my service provider if I do not understand the language being used.
I have the responsibility to notify my service provider if I am concerned about my health and safety, and I am responsible to follow all health and safety rules.
I have the responsibility to stay informed about any aspect of my illness, condition, or need for services.
I have the responsibility to make decisions to either comply or refuse medications or services.
I have the responsibility to request, if I choose, to review my record.
I have the responsibility to notify my service provider of any incompetence or legal actions.
I have the responsibility to abide by all rules and regulations and act appropriately.
I have the responsibility to understand that weapons, guns, illegal drugs, and alcohol are NOT permitted on LBHS property. I understand that law enforcement will be called if violated.
I have the responsibility to notify my service provider if I feel I have been neglected or abused.
I have the responsibility to respect the privacy of others.
I have the responsibility to file a complaint if I feel that my rights have been restricted or denied.

If at any time I feel that my rights have been violated or if I have any concerns or questions, I may contact:
**Heather Hatchett**
Chairperson, Individual Rights, Responsibilities and Ethics Committee
3120 N. Oak Street Ext, Suite C
Valdosta GA 31602
(229) 671-6109
**Department of Community Health**
2 Peachtree Street, NW
Atlanta, GA 30303
404-656-4507
**Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)**
**Office of External Affairs**
2 Peachtree Street, 24th Floor
Atlanta, GA 30303
404-657-5964
**I have read, reviewed, and had explained the Individuals' Rights and Responsibilities

**PSYCHIATRIC ADVANCED DIRECTIVE FOR MENTAL HEALTH SERVICES**

Georgia law gives the right to anyone 16 years of age and over to be involved in decisions about their mental health treatment. However, a parent or guardian of a person under the age of 18 years may authorize treatment, even over the objection of the minor. The law also notes that at times, some persons are unable to make treatment decisions. Georgia law states that you have the right to make decisions in advance, including mental health treatment decisions, through a process called a psychiatric advance directive. A psychiatric advance directive can be used to state your treatment choices or can be used to name a health care agent which is someone that will make health care decisions for you.

**I have received, read, and understand the above:**

**_____ I currently have a PAD. Copy of PAD provided to LBHS Yes____ No____**

**_____ I currently do not have PAD and request assistance with an appointed staff to make one at this time. (Requires follow up)**

**_____ I currently do not have a PAD and do not wish to have one at this time.**

**Client Printed Name: _____**

**Client/Legal Guardian Signature: _____ Date: _____**