



*Guardian initials indicate authorization of the following consents and acknowledgement:*

PATIENT NAME:

DOB:

**CONSENT FOR TREATMENT BY OBHN**

The undersigned acknowledges that no guarantee or assurance has been made to them, or the patient, as to the results of any services provided to the patient, including but not limited to therapy, treatment, tests or procedures, while a patient of OBHN. It is understood by the undersigned that the Physicians, Nurse Practitioners, Physicians Assistants and Therapists on OBHNS' medical staff exercise independent medical judgment in their treatment and evaluation of patients. The undersigned further understands that the physician(s), the physician(s) to whom the patient may be referred and other physicians who may consult or provide services to the patient may be employees of OBHN or may be independent practitioners who are not agents or employees of OBHN.

In the event of a divorce/multi-home families, OBHN will need a copy of the custody documentations from court. OBHN provides services and seeks involvement of both parents/interested parties within reason of a custody plan. If the custody is 50/50 shared then OBHN will require one parent to be the main contact/guarantor for any staff contacts and billing purposes.

**ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION FOR PAYMENT**

In consideration of any and all treatment services rendered or to be rendered by OBHN, to the extent permitted by law, I hereby (I) irrevocably assign, transfer and set over to OBHN (II) all my rights, title and interest to medical reimbursement, including, but not limited to, (III) the right to designate a beneficiary, add dependent eligibility and (IV) to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by OBHN during the pendency of the claim for care provided by OBHN. Such irrevocable assignment and transfer shall be for the recovery on said policy(ies) or insurance, but shall not be construed to be an obligation of OBHN to pursue any such right of recovery. I hereby authorize the insurance company(ies) or third party payor(s) to pay directly to OBHN all benefits due for services rendered.

**GUARANTEE OF PAYMENT**

The undersigned hereby agree(s) to guarantee the payment of the bill for services rendered by OBHN. The undersigned agree(s) whether signing as a guarantor or as a patient, that in consideration of the services to be rendered to the patient, to be hereby jointly and individually obligated to pay the account of OBHN in accordance with the regular rate and terms of OBHN. Should the account be referred for collection by an attorney or collection agency, the undersigned agree(s) to pay all attorney's fees and other reasonable collection costs and charges that are necessary for the collection of any amount(s) not paid when due. If the custody is 50/50 shared then OBHN will require one parent to be the main contact/guarantor for any staff contacts and billing purposes.

**CONSENT FOR CONTACT WITH HEALTH STUDENTS**

The undersigned acknowledges and gives permission for the patient to have contact with students of health professions during the patient's treatment. Students of health professions are supervised by a physician or nurse practitioner when they are at OBHN.

**COURT PROCEEDINGS-**

OBHN provides clinical services and does **NOT** conduct Forensic or Custody evaluations. As such we will not take part in court actions or provide opinions on court issues. Such services are available elsewhere in the community and referrals may be given as appropriate.

**STAFF CONCERNS OR COMPLAINTS-**

OBHN Follows the law and ethics code of standard when treating clients and their family/support system. If for any reason you have a concern or complaint please talk to the service provider or request for the Chief Operator Officer (COO) as the clinic does have a policy and standard for client/patient advocacy.

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### **REFILL REQUESTS-**

Monitor your medication supply so that you do not run out between appointments. If you need a refill on a medication that you have previously received from our office:

- Please contact the pharmacy that filled/fills the medication
- Ask the pharmacy to submit an electronic refill request.
- Also, please ask the pharmacy to turn off any “auto refill” functions.
- **We do require 3 business days on all medication requests. Please take weekends and holidays into consideration when calling in for refills. For your safety, please inform us of any newly prescribed medications from other prescribers and of any medication allergies.**

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### **ATTENDANCE/CANCELLATIONS/MISSED APPOINTMENTS AGREEMENT-**

Consistent attendance and active client participation is important for treatment to occur. Especially for a client and their family to meet any treatment goals it is the client’s responsibility to attend all scheduled sessions. This allows the clinic to provide timely services and support for a variety of the clients who are waiting for appointments.

#### **Appointments should be cancelled within 48 hours or more to avoid a \$50.00 missed appointment or late fee,**

I am aware that a message for cancellation can be left on the OBHN message line. The \$50 fee will need to be paid at or prior to the next appointment. It should be noted that insurance companies do not cover these late fees and the client/family will be charged the fee. Also, if a fee is not paid in a timely manner it may delay/prevent the next appointment from being scheduled. Clients can utilize crisis services at 907-563-3200 or Providence Psychiatric Emergency Room during this waiting period.

\*I understand that OBHN may discharge and close the client’s case from the clinic after three appointments have been missed. These three “missed appointments” do include both medication management and therapy services combined within a six month period. There may also be a FULL FEE charge of the third/missed appointments.

\*I understand that confirmation calls are a courtesy and that I am ultimately responsible for remembering my appointment.

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### **EMAIL CORRESPONDENCE-**

The email address [info@obhn.org](mailto:info@obhn.org) is not an encrypted or secure email address. Any email correspondence to this address is not protected. The client/client family understands the risk of sending any health information to this address is not protected health information per the Health Insurance Portability and Accountability Act (HIPAA). OBHN is not liable for this risk.

-This also applies to the staff directory and email addresses. Once a client/guardian has made this form of alternate communication they have given consent for this level of correspondence.

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### **TELE-HEALTH CONSENT-**

As part of you/your child’s treatment at OBHN you/your child may be evaluated or treated by your/their treating Physician who will work with you from another location through a secure two way video and audio connection. You/your child would sit in front of a machine that looks much like a television and talk with the Physician whom you would see on the screen. This type of video consultation is called “Telehealth”

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### **REQUEST OF OBHN RECORDS AND PROCEDURES-**

\*OBHN follows the law and when psychiatric or mental health records are court ordered we must provide that court the records.

When another health care facility, mental health clinic, or academic setting request OBHN records an OBHN release of information must be in place. \*Please note that OBHN does not charge the client/family for clinic to clinic records when they are used to continue necessary client care.

**First step-** Any request of records needs to be completed in writing and the requesting party must complete the OBHN “Release of Information” form which can be found at [www.obhn.org](http://www.obhn.org) under “The New Patient Forms” tab.

**Records Approval process-** A Licensed Health Care Professional, Psychiatrist, CEO of OBHN, or their designee must approve or deny requests for the client's electronic records to be released.

There are very few instances that a denial of records may occur but examples may include: Records that contain information subject to substance abuse or health issues. The request may breach confidentiality and could endanger the health or safety of that person. Or the information is generated in the course of ongoing research and the disclosure would jeopardize the research project.

**Records Second step-**

**Cost of Records-** OBHN charges a fee when personal use of records is requested and it is based on the number of pages.

- The first ten pages are at no-cost.
- After that, each additional page is \$0.50 cents a page.
- The fee must be paid at the time they are picked up.

**Time frame to process the records-** Once OBHN receives the records request form (Release of Information), it has been approved by a designated staff, and a fee has been quoted then the records are ready in 3-5 business days. If for any reason there is a denial of records/part of the record that decision will be made within that 3-5 day processing period.

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**PSYCHOTHERAPY SERVICES**

OBHN offers treatment provided by licensed level therapy providers. The first session is an intake and starts a diagnostic/evaluation process; it can last from 2-3 sessions. Part of the intake process includes: deciding if the clinician is the best person to help support the client and a treatment plan with therapy goals will need to be written.

**Length of Sessions**

We usually schedule hourly appointments. Approximate lengths of sessions vary up to 55 minutes face-to-face. Although in some cases the sessions may be longer or scheduled more frequently. That can be determined between the client/family and therapy provider based on the needs of the case.

**A note about privacy in psychotherapy sessions-**a therapy session has a goal to build therapeutic rapport with the teen/clients therefore some additional privacy laws and procedures are followed. If parent/caretaker can agree to respect the therapy process then during the course of treatment general information/summaries about the progress of sessions will be given by the therapy provider. When additional information outside of a briefing/check in happens it may require a client's authorization before parents can be informed about various topics protected by law.

In the case of any psychiatric/psychological emergency (e.g. harm to self or others), clients can utilize a 24 hour crisis line at 907-563-3200, or go to The Providence Psychiatric Emergency Room in Anchorage and if deemed necessary call 911.

_____	_____	_____
Printed Name of Legal Guardian	Signature of Legal Guardian	Date
	(For Minor or Incompetent Patients)	

_____	_____	_____
OBHN Staff who Reviewed Consents	Signature of OBHN Staff	Date

The parent/guardian either accepted\_\_\_\_\_ or declined\_\_\_\_\_ a copy of the consent to treat contract.