Thank you for your interest in our program. To begin the intake process you will need to complete all applicable forms as well as provide documentation of the items below.

- Registration Form
- Informed Consent for Services
- Consent for Electronic Communication
- Financial Agreement Form
- Service Orientation Handbook for Boundless Health (Your copy to keep)
- Individual Rights (Your copy to keep)
- Notice of Boundless Policies and Practices to Protect the Privacy of Individual Served's Health (Your copy to keep)
- Authorization for Release of Information (School District/Previous Providers)
- Insurance card(s) (Please provide copy in person or email: behhealthintake@iamboundless.org)
- Guardianship (Please provide copy in person or email: behhealthintake@iamboundless.org)
- Individual Education Plan (IEP) (Please provide copy in person or email: behhealthintake@iamboundless.org)
- Evaluation Team Report (ETR) (Please provide copy in person or email: behhealthintake@iamboundless.org)
- Identification Card (Please provide a copy in person or email: Behhealthintake@iamboundless.org)

Please let us know if you have any questions or if we can help in any way.

Thank you,

Customer Service & Access Team
behhealthintake@iamboundless.org
614-844-3800 ext 8181

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Registration Form

Individual Information

Name (first, middle initial, last name) :

Are you homeless or living in a homeless shelter ☐ Yes ☐ No

Current Address: Street:_____

City:_____ State:_____ Zip Code:_____

County of Residence:

Cell Phone:	**Home Phone:**
☐Can leave a detailed voicemail	☐Can leave a detailed voicemail

Email:

Date of Birth: **Social Security Number:**

Gender:

Primacy method of communication:

☐Verbal ☐ Sign Language ☐Written ☐Augmentative Device

Primary Language:

Is an Interpreter needed? ☐ Yes ☐No

Hispanic Origin?: ☐Cuban ☐Mexican ☐Puerto Rican ☐Other Hispanic Origin ☐No ☐Unknown

Race: ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black/African American

☐ Pacific Islander ☐ White ☐Other Single Race ☐ Two or more races

Disability: ☐Deaf ☐Developmentally Disabled ☐Blind/Severe Visual Impairment

☐Non-ambulation ☐Severe Medical Issues ☐ None ☐ Other:

Personal Information

Please check the individual's current living situation

☐College Dorms ☐Relative's Home ☐Rent Home

☐With Guardian (not parents) ☐With Parents ☐Own Home

☐With Foster Parents ☐24-Hour Residential Care ☐Other:_

Please check the individual's employee status

☐Employed-Full Time ☐Unemployed-Not seeking Work ☐Retired □ Unemployed-seeking work

☐Employed-Part Time ☐Student ☐Disabled ☐Not in Workforce

☐Age 0-5 ☐Other:_____

U.S. Citizen: ☐Yes ☐No

Religous preference (if applicable):

Is the individual currently serving in the Military: ☐Yes ☐No

Is the individual a veteran: ☐Yes ☐No

Is this a Court Ordered Service: ☐Yes ☐No

Does the individual have any involvement with the Justice System: ☐Yes ☐No
If checked "Yes", please check one of the following:

☐N/A ☐Incarcerated-Jail ☐Detained-Jail

☐Arrested ☐Incarcerated-Prison ☐Mental Health Court

☐Charged with a Crime ☐Juvenile Detention Center ☐Other:

Highest completed education level (please mark one of the Following):

☐Regular Education Classes ☐Continuing Education/College

☐Special Education Classes (has an IEP) ☐Vocational Training

☐High School Diploma/GED

Current education status (please mark one of the following):

☐Regular Education Classes ☐Continuing Education/College

☐Special Education Classes (has an IEP) ☐Vocational Training

☐High School Diploma/GED

Additional Information

Does the individual have an Advanced Life Directive: ☐Yes ☐No

SSI/SSDI Status:

☐N/A ☐Potentially Eligible- Has not applied

☐Eligible-Receiving Payments ☐Determined to be ineligible

☐Eligible-Not Receiving Payments ☐Eligibility Status Unknown

☐Eligibility Determination Pending

Tobacco Use (Please check One):

☐Never Used ☐Has Used/Not Current Use ☐Occasional Use

☐Regular Use ☐Use Smokeless Tobacco ☐Unknown/No Longer Allowed

Primary Care Physician: ☐Yes ☐No
If Yes", Please Provide the following information:

First Name: _____Last Name: _____

Organization: _____ Phone:_____

Address: _____

Current Behavioral Health Care Provider (if applicable):

First Name: _____Last Name: _____

Organization: _____ Phone:_____

Address: _____

Previous Mental Health Services (please include ANY information-Name of facility, Dates, treatment):

Facility Name_____

Dates of Treatment _____

Type of service Received (check all that apply):

☐State Hospital ☐Psychiatric Hospital ☐General Hospital

☐Outpatient ☐Residential (non-hospital) ☐Substance Abuse/Outpatient

Referral Source

If you were referred to our services, who referred you?

☐ Another Boundless Client ☐Boundless Comminuty Liaison ☐Boundless Website ☐Clergy ☐Community Event

☐ Correctional/Legal ☐ County Board od DD ☐ County Childrens Services ☐ Education

☐ Employer/Employer Assistance ☐ Family/Friend ☐ Insurance Company ☐ Medical Organization

☐ Mental Health Agency ☐ Military ☐ Parent Group (Facebook) ☐ PDP ☐ Residential ☐ Self ☐ Shelter

☐ Social Media ☐ Other

Referral Organization Name:
Referral Organization Phone:

Refrral Source Name:
Refrral Source Phone:

Referral Organization/Source Address:

Email:

Insurance

Medicaid or Medicare Plan? ☐ Yes ☐No
If yes, what is your Medicaid ID (MMIS):

Insurance Provider:

Subscriber Name:

Subscriber Date of Birth:

Subscriber Relationship to Individual Served:

Member ID:

Group Number:

Contact Phone Number:

Contacts

Name:_____Relation:_____

Cell Phone:_____ Home Phone: _____

Email:_____ Address: _____

Check ALL That Apply:

☐Financially Responsible ☐Guardian ☐Schedule Appointments

☐Emergency Contact ☐Household Member ☐Care Team Member

Name:_____Relation:_____

Cell Phone:_____ Home Phone: _____

Email:_____ Address: _____

Check ALL That Apply:

☐Financially Responsible ☐Guardian ☐Schedule Appointments

☐Emergency Contact ☐Household Member ☐Care Team Member

Name:_____Relation:_____

Cell Phone:_____ Home Phone: _____

Email:_____ Address: _____

Check ALL That Apply:

☐Financially Responsible ☐Guardian ☐Schedule Appointments

☐Emergency Contact ☐Household Member ☐Care Team Member

Name:_____Relation:_____

Cell Phone:_____ Home Phone: _____

Email:_____ Address: _____

Check ALL That Apply:

☐Financially Responsible ☐Guardian ☐Schedule Appointments

☐Emergency Contact ☐Household Member ☐Care Team Member

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Informed Consent for Services

I understand that I am eligible to receive a wide range of services through Boundless Health, Inc. 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 an Individualized Treatment Plan (ITP) or Person-Centered Plan.

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

I understand that services may be provided by a range of health 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 may ask to meet with my treatment provider's supervisor at any time.

I also understand that clinical records may be reviewed by a Quality Assurance/Compliance departments at Boundless 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 accreditation, certification or authorizations. Additionally, if I apply for all or part of my treatment to be funded by various third parties other than Medicaid/Medicare, 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.

Boundless Health's Individuals Served Grievance Procedures, Individuals Served Rights and Responsibilities and Notice of Privacy Practices have been explained to me and I have been offered and received my own copy if requested. If Boundless Health's Notice of Privacy Practices should change, you will be notified of the change by receipt of the new Notice of Privacy Practices which will also be posted at all Boundless locations.

To provide treatment to minors, Boundless Health is required to obtain consent for treatment from the minor's legal guardian or custodian. By signing below, you are attesting that you are legally or custodial responsible for the minor named below or are consenting for services for yourself by Boundless Health.

_____	_____	_____
Individual Served Name	Signature of Individual Served, Parent /Legal Guardian, Custodian, or Authorized Representative	Date

You have the right, at any point, to refuse treatment. If you choose to refuse treatment, Boundless Health 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. If you refuse treatment, please sign below.

I hereby refuse my consent for Boundless Health to provide treatment to me and/or for my minor child(ren). The effects of this decision along with potential consequences have been explained to me and efforts have been made to offer help in developing alternative treatment approaches.

_____	_____
Signature of Individual Served, Parent /Legal Guardian, Custodian, or Authorized Representative	Date

You have the right to withdraw consent for treatment at any time. If you choose to withdraw consent, Boundless Health staff will explain any implications or potential consequences for withdrawing treatment. If you have chosen to withdraw consent for treatment, please sign and date below.

I hereby withdraw my consent for Boundless Health to provide treatment for me and/or for my minor child(ren). The efforts of this decision and potential consequences for withdrawing consent have been explained to me and efforts have been made to offer help in developing alternative treatment approaches.

_____	_____
Signature of Individual Served, Parent /Legal Guardian, Custodian, or Authorized Representative	Date

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Financial Agreement and Payment Authorization

This document will serve as the basis for the payment agreement between _____ and/or the indicated responsible party and Boundless Health for services rendered on behalf of the above individual served.
Client's Name

1. It being understood that fees are charged for all services rendered by Boundless Health. Fees are subject to change and any increase or decrease will be passed on to the client and third-party payers. Boundless Health 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, Boundless Health will first bill any insurances/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 will be responsible for the remaining amount. (Exceptions to this are limited to specific contracts.) If desired, we 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. This includes payments 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 immediately, and prior to subsequent visits, report to Boundless Health any changes in insurance coverage, including termination, that affects dates on which you received or will receive services. Boundless Health 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, I verify that the insurance/third-party payer information supplied is true and accurate to the best of my understanding. I also authorize Boundless Health to release to appropriate third party payers information regarding treatment and services provided as may be necessary for the evaluation and payment of claims made. Finally, I authorize that payment of these medical benefits be made directly to Boundless Health. I understand that if my insurance company is not timely in paying Boundless Health directly, it is my responsibility to keep my account current while awaiting payment.

6. For returned checks a $35 NSF (Nonsufficient Funds) charge is applied to balance owed. If not paid according to terms, the responsible party understands that Boundless Health reports to an outside collection agency. In the event that an account is turned over for collection, the responsible party agrees to pay all additional fees assessed in the collection of the debt. These fees may include collection agency fees and attorney fees. The responsible party is ultimately responsible for all fees for service.

7. Payment for copays, deductibles, and non-covered services, is expected at each visit. Failure to pay for services may call for your services to be terminated and legal collection action or other appropriate action to be taken. For your convenience we accept debit cards, MasterCard, VISA, and Discover, as well as cash and personal checks.

8. Boundless is committed to continuing care of services, however if an outstanding balance exceeds $500.00, Boundless reserves the right to not schedule future appointments until the balance is below $500.00. Boundless will work with individuals regarding payment plans and strategies to help reduce balances to assist in continuation of treatment. .

Signature of Party Responsible for Fee_____ Date: _____

Responsible Party's Social Security Number (if different than client): _____

Relationship(of the person signing to Individual Served):_____

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Telehealth Informed Consent Form

Individual Served Name:_____ Individual Served 's Date of Birth: _____

If, during the course of service delivery with Boundless Health (Boundless), 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:

1. I have the right to withhold or end consent at any time without affecting my right to receive other or future care or treatment.
2. 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.
3. 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 Boundless, that:
   a. Telehealth-based services and care may not be as complete and 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.
   b. 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 Boundless. I agree that I am aware of these potential issues and will not hold Boundless or its staff liable for the actions of persons or companies outside of Boundless' control.
   c. There may be risks to my health if I am in a crisis or emergency and Boundless' 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.
4. I understand I have the right to access copies of my protected health information in accordance with applicable laws, standards, regulations, and Boundless' policies and procedures.

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

Signature: _____ **Date:** _____

(Sign with full legal name)

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Consent for Electronic Communication

Individual Served Name:_____ Individual Served 's Date of Birth:_____

Boundless Health 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 Boundless Health, I understand and consent to the following:

1. I understand that federal and Ohio laws protecting the privacy and confidentiality of patient information apply to electronic communication of that information. Boundless Health 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.
2. I understand that despite reasonable and compliant efforts to protect the privacy and security of electronic communication transmitted or received by Boundless Health, 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 who may access my phone, computer, or other devices that I use to communicate with Boundless Health, b) Loss of my cellular phone, computer, or other devices, c)Email accounts being hacked or mis-delivery of 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 Boundless Health, and f) Any additional risks that may be a result of unsecured Internet and/or email use.
3. I understand that electronic communication can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
4. I understand that electronic communication may be disclosed in accordance with applicable mandated reporting requirements under the law.
5. 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.
6. I understand that electronic communication is not an appropriate substitute for in-person or over-the-telephone communication with providers.
7. I understand that Boundless Health, is not responsible for information loss due to technical failures associated with my software or internet service provider.
8. I understand that I have the right to revoke my consent for electronic communication and that it is my responsibility to notify Boundless Health, 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 Boundless Health I also acknowledge that I am consenting to the use of my electronic signature on applicable documents for the purpose of service delivery by Boundless Health, and all of its affiliated companies.

Signature: _____ Date:_____

(Sign with full legal name)

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Health History Questionnaire

This form should be completed as fully as possible by the Individual or parent/guardian but reviewed by medical or clinical staff. Individuals should notify staff if they need any assistance in completing this form.

Individual Name: (First, MI, Last)	**Age:**
Known Medication Allergies/Sensitivities to Medications:	
Reaction(s):	
Other Allergies/Reaction(s):	

Current Medications

Medication Name	Dosage	Amount Taken	Prescriber

Over the Counter and/or Herbal Supplements

Supplement Name	Dosage	Amount Taken	

Has the Individual had any of the following health issues?

Health Problems	Please check all that apply
Psychiatric	☐Developmental (Autism, Intellectual Delay) ☐Depression ☐Anxiety ☐ADHD ☐Bipolar/Mood Disorder ☐Schizophrenia ☐Eating Disorder ☐Sleep Disorder ☐Personality Disorder ☐Oppositional Defiant/Conduct Disorder ☐Other _____
Cardiovascular/Heart Disease	☐Hypertension/Blood Pressure ☐Clotting disease ☐Arrhythmia/Abnormal Heart Rate/Rhythm
Endocrinology/Nephrology	☐Diabetes ☐Kidney Disease ☐Thyroid Problems
Neurological	☐Seizure Disorder ☐Epilepsy ☐TBI ☐History of Stroke/TBI ☐Headaches
Gastrointestinal	☐Stomach/Bowel Problems ☐Gastric Bypass Surgery
Hepatology (Liver)	☐Cirrhosis ☐Hepatitis ☐Jaundice
Musculoskeletal	☐Fibromyalgia ☐Neuropathy
Ophthalmology	☐Glaucoma ☐Macular Degeneration

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

Suicidal Ideation

Any current thoughts of self-harm/injury: ☐No ☐Yes If yes, please answer the following questions:

Do you currently have a plan/intent? ☐No ☐Yes If yes, please describe current plan.

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How long have you had suicidal or self injurious thoughts:_____months_____years

How frequent do you have these thoughts: ☐Monthly ☐Weekly ☐Daily

Current Supports (Please list name, relations and contact number (if applicable)

Name	Relation	Contact Number

Has the Individual had Psychiatric Hospitalizations? ☐Yes ☐No If yes, complete information below

Has the Individual had past medical hospitalizations? ☐Yes ☐No If yes, complete information below

Hospital	City	Date	Reason

Severity of Mental Health Associated Symptoms

Do concerns related to mental health currently interfere with your activities? ☐No ☐Yes

If yes, how much does it interfere with these activities? ☐Not at all ☐Mildly ☐Moderately ☐Severely ☐Extremely

Please Indicate what symptom(s) are most concerning, or the cause of interference of daily activities?

Primary Care Physician

Name of PCP (Primary care Provider):	Date last seen:	Treatment Provided:

Immunizations

☐NA **Are you current with your immunizations?** ☐No ☐Yes

Pregnancy History (if applicable)

☐NA Currently Pregnant? ☐Yes ☐No If yes, expected delivery date._____

Nutritional Screening (please check)

☐No Problem	**Eating** ☐More ☐Less ☐Not Eating	**Drinking** ☐More ☐Less ☐Takes Liquids Only	**Appetite** ☐Increased ☐Decreased

Associated Symptoms: ☐Nausea ☐Vomiting ☐Trouble Chewing or Swallowing ☐Special Diet ☐Other

Substance Use History/Current Use (please check appropriate columns)

Alcohol	☐No Use	☐ Past use; if so, when last used:_____ ☐Current Use; if so, how often: _____
Marijuana	☐No Use	☐ Past use; if so, when last used:_____ ☐Current Use; if so, how often: _____
Cocaine/Crack	☐No Use	☐ Past use; if so, when last used:_____ ☐Current Use; if so, how often: _____
Heroin	☐No Use	☐ Past use; if so, when last used:_____ ☐Current Use; if so, how often: _____
Pain Medication/ Opiates	☐No Use	☐ Past use; if so, when last used:_____ ☐Current Use; if so, how often: _____
Stimulants	☐No Use	☐ Past use; if so, when last used:_____ ☐Current Use; if so, how often: _____
Benzodiazepines	☐No Use	☐ Past use; if so, when last used:_____ ☐Current Use; if so, how often: _____
Caffeine Use	☐No Use	If yes, from (coffee, tea, pop, etc.) How much per week (cups, bottles)?
Tobacco Use	☐No Use	If yes, from (cigarettes, cigars, smokeless, etc.) How much per week (packs, etc.)?

Print name of person Completing this Questionnaire	Signature

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. he information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY Boundless
ADDRESS	ADDRESS 445 East Dublin Granville Road
CITY/STATE	CITY/STATE Worthington, Ohio 43085

☐ **Reciprocal Release Authorization** (when checked, authorizes two-way exchange of Protected Health Information between the above-named persons or entities).

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other *(Specify)* _____

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

_____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (Billing, etc.)* _____

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes **ONLY** (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Boundless Intake Coordinator, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

_____
(Specify new date)

I understand that Boundless will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

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Instructions for Completing
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.

2. Section I, print your name or the name of patient whose information is to be released.

3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.

4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc. **CHECK THE RECIPROCAL RELEASE AUTHORIZATION BOX IF YOU WISH TO AUTHORIZE BOTH ENTITIES OR PERSONS LISTED IN SECTION II TO EXCHANGE YOUR PROTECTED HEALTH INFORMATION. THE ENTITY/PERSON OTHER THAN BOUNDLESS MAY ALSO REQUIRE YOU TO COMPLETE AN ADDITIONAL FORM OR FOLLOW PROCEDURES ESTABLISHED BY THAT ENTITY/PERSON TO AUTHORIZE THIS EXCHANGE OF INFORMATION. IF YOU CHECK THE RECIPROCAL RELEASE AUTHORIZATION BOX AND LATER DECIDE TO REVOKE THIS AUTHORIZATION, YOU MUST NOTIFY BOTH ENTITIES OR PERSONS OF THAT REVOCATION IN WRITING.**

5. Section IV, check the appropriate box as applicable.

   a. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.

   b. **Only the period of events from** -- specify date range, e.g., Jan. 1, 2019, to Feb. 1, 2020.

   c. **Other *(specify)*** -- e.g., Billing.

   d. **Entire Record** -- complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).

   e. **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.**

   f. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

6. Section V, if a different *expiration* date is desired, specify a new date.

7. Section V, please sign (or mark) and date.

8. A copy of the completed authorization form will be given to you.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. he information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY Boundless
ADDRESS	ADDRESS 445 East Dublin Granville Road
CITY/STATE	CITY/STATE Worthington, Ohio 43085

☐ **Reciprocal Release Authorization** (when checked, authorizes two-way exchange of Protected Health Information between the above-named persons or entities).

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other *(Specify)* _____

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

_____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (Billing, etc.)* _____

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes **ONLY** (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Boundless Intake Coordinator, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

_____
(Specify new date)

I understand that Boundless will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

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Instructions for Completing
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.

2. Section I, print your name or the name of patient whose information is to be released.

3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.

4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc. **CHECK THE RECIPROCAL RELEASE AUTHORIZATION BOX IF YOU WISH TO AUTHORIZE BOTH ENTITIES OR PERSONS LISTED IN SECTION II TO EXCHANGE YOUR PROTECTED HEALTH INFORMATION. THE ENTITY/PERSON OTHER THAN BOUNDLESS MAY ALSO REQUIRE YOU TO COMPLETE AN ADDITIONAL FORM OR FOLLOW PROCEDURES ESTABLISHED BY THAT ENTITY/PERSON TO AUTHORIZE THIS EXCHANGE OF INFORMATION. IF YOU CHECK THE RECIPROCAL RELEASE AUTHORIZATION BOX AND LATER DECIDE TO REVOKE THIS AUTHORIZATION, YOU MUST NOTIFY BOTH ENTITIES OR PERSONS OF THAT REVOCATION IN WRITING.**

5. Section IV, check the appropriate box as applicable.

   a. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.

   b. **Only the period of events from** -- specify date range, e.g., Jan. 1, 2019, to Feb. 1, 2020.

   c. **Other *(specify)*** -- e.g., Billing.

   d. **Entire Record** -- complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).

   e. **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.**

   f. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

6. Section V, if a different *expiration* date is desired, specify a new date.

7. Section V, please sign (or mark) and date.

8. A copy of the completed authorization form will be given to you.

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Orientation Check List

Individual Served's Name:_____Date: _____

I affirm the following topics were provided to me in the Boundless Health Handbook, or will be provided to me upon completion of my Diagnostic Assessment. Additional information may be provided up request. If you have any additional questions, please touch base with your primary clinician.

1. Individual Fee explanation, Financial Arrangement, fees, obligations
2. Confidentiality
3. Individual Rights and Responsibilities
4. Purpose and Process of assessment
5. Individual Treatment Plan/Person-Centered Plan and development and Individual participation
6. Ways in which Individual input is given: i.e. quality of care, outcomes, and satisfaction
7. Developing feasible goals and achievements of outcomes
8. Identification of primary clinician.
9. Hours of operation
10. Access to after-hours service
11. Site and Safety Organization
12. Tobacco, illicit/licit drugs, medications and weapons brought into the program
13. Grievance and Appeal Procedures
14. Policy on Seclusion and Restraint
15. If applicable, the identification of therapeutic interventions including sanctions, incentives, and administrative discharge criteria
16. Program Rules, regulations and expectations
17. Discharge/transition criteria and procedures
18. Mandated reporting

_____ _____

Individual Signature Date

_____ _____

Parent/Guardian Signature (If applicable) Date

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Service Orientation Handbook for Boundless Health

2021

Welcome

We would like to welcome you to Boundless Health! Please review this handbook to understand agency expectations and guidelines for services.

Our Mission: Building a world that realizes the boundless potential of all people.

Locations & Contact Information

Main Phone Number: 1-800-409-2729

Medina, Ohio
1065 Medina Road, Suite 300 Medina, OH 44256
Office: 330-596-1042 ext. 2244 Email: info@iamboundless.org

Newark, Ohio
22 N. 1st St. Newark, OH 43055
Office: 740-334-4056 Email: info@iamboundless.org

Worthington, Ohio
445 E. Dublin Granville Rd Worthington, OH 43085
Office: 614-844-3800 Email: info@iamboundless.org

West Carrollton, Ohio
700 Liberty Lane West Carrollton, OH 45449
Office: 937-247-2400 Email: info@iamboundless.org

Youngstown, Ohio
Mahoning Valley Campus of Care
1960 East County Line Road, Bldg 6B Mineral Ridge, OH 44440
330-596-1042 ext. 2029 Email: info@iamboundless.org

Hours of Operation

Monday: 8:00am- 6:00pm
Tuesday: 8:00am- 6:00pm
Wednesday: 8:00am- 6:00pm
Thursday: 8:00am- 6:00pm
Friday: 8:00am- 5:00pm
Saturday: Closed
Sunday: Closed
Additional evening hours may be available based on availability of individual clinicians.

Boundless will be closed on the following holidays:
New Year's Day
Memorial Day
Independence Day
Labor Day
Thanksgiving
Christmas Day

Day Treatment and Center-based programs may have a varying schedule. Schedules will be provided upon enrollment.

Crisis Services
If you are experiencing a behavioral health emergency that requires immediate care, call 911 or go to your nearest emergency room. You may also call Boundless Health 24 hours a day, 7 days a at 1-800-409-2729. You will be directed to the clinician on call.

Boundless Health Handbook

Please review this handbook to understand the agency expectations and guidelines for services.

Boundless Health is a private non-profit community mental health center. Boundless is a leader in delivering exceptional results for individuals with autism, developmental disabilities and complex behavioral health issues. We are committed to maximizing your progress by applying evidence-based strategies. Our unique approach allows individuals to receive customized, integrated treatment that incorporates behavioral health, family supports, and educational services. As part of our ongoing commitment to providing quality services, Boundless maintains accreditation by CARF (Commission on Accreditation of Rehabilitation Facilities) to provide Outpatient Treatment, Day Treatment and Case Management/Service Coordination.

Our Outpatient Behavioral Health Services Handbook provides you with information about our program as well as relevant policies and procedures to clarify expectations for the services you will receive. If you have questions about any information provided in the handbook or any other aspect of the services you will be receiving, please do not hesitate to contact your case manager or clinician at Boundless.

Program Goals

Boundless' programs utilized a person-centered approach. We strive to work with the individual and care providers to develop appropriate goals and objectives to reach their desired level of functioning and to assist in achieving treatment goals.

Evidence-based behavior and cognitive therapy approaches represent the foundation of our counseling and therapy practice. Treatment will vary in the level of frequency and intensity based upon the individual's needs and is provided in coordination with other services with which the person may be involved.

Service Overview

Boundless is pleased to offer a variety of outpatient and community based behavioral health services as part of our growing continuum of treatment programs. Outpatient treatment services are provided to a wide array of individuals with behavioral health concerns. Programs are specialized in serving children, adolescents and adults with co-occurring behavioral health and developmental disabilities, autism and complex behavioral health issues. Treatment is individualized and employs a strength-based approach designed to decrease the impact of their symptoms on daily functioning and increase independence.

Boundless Health services may include but are not limited to:

- Diagnostic Assessments are completed for all individuals in a manner that is respectful and considerate of the individual's specific needs. The Diagnostic Assessment is completed to evaluate a individual's need and determine appropriate level of services offered. Assessments are updated as needed (but no less than yearly) to address any changes in behavioral health needs and guide treatment.
- Case Management services promote the individual's ability to succeed in the community, identify and access needed services, build skills, and assist with coordination of care. These services may occur in support of other services provided by Boundless or other providers.

- Pharmacological Management services provide psychiatric evaluations and medication management for children, adolescents and adults. In many instances, the combination of medication and other behavioral health interventions produce the best results. Our focus is providing integrated care to help reduce symptoms and improve overall functioning.
- Medical Services including behavioral health nursing services and speech services.
- Psychological Testing is available to children, adolescents and adults to help provide diagnostic clarification and relevant treatment recommendations using a combination of psychological tests, clinical interviews, behavioral observations and review of collateral records with a specific focus on developmental disabilities, autism spectrum disorders, complex learning disabilities and Attention Deficit/Hyperactivity Disorder.
- Pre-Academic Skills Evaluations assess skills related to expressive and receptive language, cooperation, motor functioning, problem solving skills and early academic abilities prior to the start of center-based services.
- Behavioral Health Therapy may be available in many forms based on the individual and family needs and recommended treatment goals and may include:
    - Individual therapy
    - Family therapy
    - Parent training and education
    - Couples therapy
- Day Treatment services are offered to during set times to specific populations, based on program location. The programs address complex needs by providing behavioral interventions using evidence- based techniques to develop and restore social skills and daily functioning. Crisis prevention, de- escalation, and symptom reduction are targeted to support the individual's in achieving their maximum potential.

Payer Sources & Fees

Behavioral health services can be covered by private insurance, Medicaid, Medicare, managed care plans, or private pay. Coverage is based upon insurance providers and plans, and prior authorization may be required for some services. Fees are based on established rates, and a sliding fee scale is available for individuals who qualify. Boundless accepts cash, check and major credit cards. All fees and co-pays are due at the time of service.

Referral Sources

Referrals for services may be made directly by service coordinators, schools, family, courts, therapists, psychologists, emergency service agencies, state departments, hospitals, and other professionals. Individuals may self-refer as well. Referrals and information provided shall assist the person served in accessing appropriate services.

Orientation

The information provided in this handbook provides orientation to inform you of the services provided, the expectations, policies and procedures to help achieve a seamless transition into the services provided. This handbook will help you stay informed about important information about our agency. If you have any additional questions or concerns, please ask your clinician.

Policies, Rules and Expectations

Boundless is required to provide this Notice to you by the Health Insurance Portability and Accountability Act (HIPAA). This notice describes how Boundless protects your personal health information which relates to the services we provide to you and how we may use and disclose this information. Boundless is required to maintain the privacy of your records and health information. All individuals will be notified of reportable breaches of privacy and security. A copy of HIPAA rights titled (Notice of Privacy Practice-Your Individual Rights Under HIPAA) is available in the waiting room and upon request.

- Additional information on Individual Served's Rights is available in the tri-fold titled (Individual Served's Rights) which is available in the waiting room and upon request.

Site and Safety Organization: Emergency evacuation maps are in every room next to the door, identifying exits, first aid kits and fire extinguisher. Please reference in case of an emergency.

Tobacco, Illicit/licit drugs and weapons: We are a drug, smoke, tobacco and weapon free facility. Please do not bring any of these items onto campus or into the buildings.

Confidentiality: All information obtained by Boundless Health, Inc. about you, your child or ward is strictly confidential. Information can be released only with a written, specific release signed by you or the parent/guardian (if applicable). Boundless staff members have access to confidential information and are required to demonstrate professionalism. Discussion of the individual must be confined to parties who are professionally involved with the individual's assessment and diagnosis, enrollment or treatment. Any case discussions will be conducted in a professional manner and in an appropriate place. Individuals will never be discussed in public.

Limits on Confidentiality

Boundless is responsible for the release of Individual PHI in the following circumstances:

- Any and all suspected child abuse incidents must be reported
- Any court orders to release records is received
- Duty to Warn- If you are a danger to yourself or others
- If you waive your right or give consent
- If the insurance company paying for services requests to review records

Individual Fee Explanation, Financial Arrangements, Fees and Obligations: Each individual is responsible for providing the appropriate information to bill for services provided. Individuals take full responsibility for any outstanding payments not covered by other funding sources/payors.

Individual Treatment Plan and Development and Individual Participation: It is incredibly important that the individual/guardian is actively involved in the development of the individual treatment plan. The development of the individual treatment plan can include a review of the assessments and treatment recommendations with the individual, family/guardian and members of the treatment team.

Treatment Non-Compliance: Non-compliance with treatment, including frequent no-shows or cancelations, or failure to cooperate or participation in treatment, may result in termination from services. Ways in which individuals' input is given, quality of care, outcomes and satisfaction: Individuals are encouraged to provide feedback regarding the service they receive. This can be through meetings, review of the service provided and progress towards goals, and through customer satisfaction surveys. It Participation and feedback from family/guardians or other members of the treatment team is also encouraged as appropriate.

Developing feasible goals and achievements or outcomes: As part of the development of the individual treatment plan, the individual and/or their family/guardian will, through a collaborative effort with the treatment team, create appropriate goals and objectives that address current concerns and are obtainable.

Expectations: It is expected for all individuals and/or family/guardians to participate in the services provided. This includes, but is not limited to, arriving on time for scheduled appointment and actively participating in assessment and treatment sessions.

Information for discharge/transition criteria: Individuals may voluntarily terminate services at any time. Discharge planning, referral to other services and coordination with other providers is offered if desired. Individual's may also be discharged from the service for frequent "no show" or missed appointments. See appointment/cancellation section for our "No Show" policy.

Policy on Seclusion and Restraint: Seclusion and mechanical restraints are not utilized in outpatient or community-based services.

Behavior Management and Crisis Intervention: Boundless does not tolerate acts of physical aggression or verbally threatening behavior towards any staff, visitors, other individuals or volunteers at the agency. If acts of aggression or any other threatening behavior is to occur on the premises, the agency shall assess if services shall be suspended or terminated as well as determining if a higher level of care is required. If aggressive or threatening behaviors cannot be reduced, it may be necessary for law enforcement to be contacted to maintain a safe environment.

Treatment Risk/Benefits: There may be some risks to treatment provided. Potential risks include, but are not limited to, experiencing a certain level of discomfort while working towards treatment goals and medication side-effects. All relevant risks will be discussed as part of the treatment planning process.

Appointments/Cancellations: Boundless Health requires that individuals provide at a minimum a 24-hour noticed for any canceled appointment. If a individual has multiple consecutive no shows for appointments, the individual may be discharged from services. A discharge letter will be provided to the individual.

- Boundless Health may have to cancel appointments for individuals due to unforeseen circumstance including, but not limited to clinician vacation or illness. Every effort to provide notice of such cancellations and timely rescheduling of appointment will be made.
- Late arrivals for scheduled appointment (15 minutes or more) may result in appointments being rescheduled depending on the availability to the clinician.
- Our No Show / Cancellation Policy is stated below.
    - A "No Show" refers to a missed appointment or an appointment that is cancelled less than 24 business hours before the scheduled appointment time.

        1. After 1st "No Show" a review of the appointment policy will be provided during rescheduling.

        2. After the 2nd "No Show" for a scheduled appointment within 3 months of the first no show appointment, a letter to reschedule the appointment will be provided.

        3. After the 3rd "No Show" for a scheduled appointment within 6 months of the first no show appointment, services shall be terminated. A discharge letter will be mailed and resources/referrals to other providers will be offered.

        4. If a individual reaches out to schedule after being discharged, they will need to complete a new Diagnostic Assessment and be re-assigned to a provider.

        5. Medications will not be re-filled after discharge from Psychiatry Services without a new Diagnostic Assessment and a follow-up appointment with a member of the Psychiatry Team.

Medication Refills: If a individual needs a medication refill, the medication refill request shall be provided at least 5 days prior to the medication running out. Changes to medication require an appointment with the prescriber. Additionally, your prescriber may require a face-to-face appointment prior to refills being filled, especially if regularly scheduled follow-up appointments have been cancelled or missed. Medications will not be re-filled after discharge without a new Diagnostic Assessment and follow-up appointment with a member of the Psychiatry team.

Dispensing/Samples/Administering Medication: Boundless does not store nor dispense sample medications to individuals engaged in outpatient or community based behavioral health services.

Mandated Reporter: In the State of Ohio, all staff of Boundless are considered mandated reporters with regards to suspected abuse and neglect. Mandated reporters are not required to provide their name to make a report and the identity of the reporter shall not be released for use. Any suspected abuse or neglect shall be reported according to state and federal law. See Ohio Revised Code 2151.421.

Grievance Process

Each individual receiving services has the right to file a grievance. An individual may file a grievance at any time. If the individual requires assistance in completing the grievance, the Client's Rights officer may assist them with this process. This procedure is posted in all buildings for reference.

It is inevitable in any organization that conflicts will arise. A professional organization is one in which the members handle these conflicts in a constructive manner. It is the purpose of these procedures to describe a process for 1) addressing concerns and conflicts in such a constructive manner, and 2) filing a formal grievance with the Client Rights Officer in addition to, and/or if the steps to addressing concerns does not meet satisfaction of the individual.

Step 1: Emotionally prepare.

- Take a few minutes to collect your thoughts.

Step 2: Intellectually prepare.

- Define the problem with clear descriptions.
- Consider the who, what, when and how regarding the problem.
- Define the outcomes that you desire.
- Determine with whom you should discuss the problem.

Step 3: Discuss the issue.

- Schedule an appointment to discuss your concerns
- All grievances must be in writing.
- All grievances must be filed within a reasonable period of time from the date of when the grievance occurred.

A full copy of the grievance process is available at any time.

Client Rights and Privacy Officer Contact Information

Clients Rights Officer: Susie Burke

Location: 445 East Dublin-Granville Rd.

Worthington, Ohio 43085

Phone: 614-844-3800 Ext. 3269

Email: sburke@iamboundless.org

Hours: Monday to Friday 9:00 AM to 4:00 PM

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Grievance Process

It is inevitable in any organization that conflicts will arise. A professional organization is one in which the members handle these conflicts in a constructive manner. It is the purpose of these procedures to describe a process for 1) addressing concerns and conflicts in such a constructive manner, and 2) filing a formal grievance with the Individual Served's addition to, and/or if the step of addressing concerns does not meet satisfaction of the griever.

Step 1: Emotionally prepare.

- Take a few minutes to collect your thoughts.

Step 2: Intellectually prepare.

- Define the problem with clear descriptions.
- Consider the who, what, when and how regarding the problem.
- Define the outcomes that you desire.
- Determine with whom you should discuss the problem.

Step 3: Assertively discuss the issue.

- Schedule an appointment to discuss your concerns
- All grievances must be in writing.
- All grievances must be filed within a reasonable period of time from the date of when the grievance occurred.

A full copy of the grievance process is available at all times.

Individual Served's Rights Officer: Susie Burke
445 East Dublin Granville Road, Bldg. G
Worthington, Ohio 43085
Phone: 614-844-3800 ext. 3269
Email: sburke@iamboundless.org
Hours: Monday-Friday
9 a.m.-4 p.m.

Individual Served's Rights

Copies of the policy and procedure are available upon request.

Policy and Procedure 900

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Your Individual Rights

- The right to be treated with consideration and respect for personal dignity, autonomy and privacy.
- The right to receive service in a humane setting, which is the least restrictive feasible as defined in the treatment plan.
- The right to be informed of one's own condition, of proposed or current services, treatment, or therapies, and of the alternatives.
- The right to be informed and consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent or refuse any service, treatment or therapy on behalf of a minor child.
- The right to a current, written individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral. (Individuals have the right to receive a copy of one's own individualized treatment plan.)
- The right to actively participate and informed participation in the establishment, periodic review, and reassessment of the service plan and including services necessary upon discharge and to receive a copy of their plan.
- The right to freedom from unnecessary or excessive mediation.
- The right to freedom from unnecessary restraint or seclusion, unless there is an imminent risk of physical harm to self or others.
- The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the Individual's participation in other services. This necessity shall be explained to the client and written in the client's current service plan.
- The right to be informed of and refuse any unusual or hazardous treatment procedures.
- The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, television, movies, or photographs or other audio and visual technology. This right does not prohibit the agency from using closed-circuit monitoring to observe a seclusion room or common area.
- The right to have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense.
- The right to confidentiality of communications and of all personal identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized by the Individual or parent or legal guardian of a minor Individual or court-appointed guardian of the person of an adult Individual in accordance with Rule 5122:2-3-11 of the Administrative Code.
- The right to request to restrict treatment information being shared and the right for information to be exchanged with a release of information. The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for the individual Individual for clear treatment reasons in the Individual's treatment plan. "Clear treatment reasons" shall be understood to mean only severe emotional damage to the Individual such as dangerous or self-injurious behavior is an imminent risk. The person restricting the information shall explain to the Individual the factual information about the individual Individual that necessitates the restriction. The restriction must be renewed at least annually to retain validity. Any person authorized by the Individual has unrestricted access to all information. Individuals shall be informed in writing of agency policies and procedures for viewing or obtaining copies of personal records. Any restricted access shall have a goal to have the restricted access removed and shall document the reason for the restriction within the treatment plan.
- The right to be informed in a reasonable amount of time in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for consequences of that event and provided a referral for further services, unless deemed not necessary.
- The right to receive an explanation of the reasons for denial of service.

- The right not to be discriminated against in the provision of service on the basis of religion, race, ethnicity, color, creed, sex, sexual orientation, genetic information, human immunodeficiency virus status, national origin, age, life-cycle, physical or mental handicap, developmental disability, or inability to pay.
- The right to protection against discrimination as stated in the Americans with Disabilities Act of 1990 (Public Law 101-336).
- The right to know the cost of services.
- The right to exercise any and all rights without reprisal in any form, including continued uncompromised access to service.
- The right to file a grievance following the Grievance Procedure including to appeal a decision.
- The right to have oral and written instructions for filing a grievance, with assistance if requested.
- The right to be verbally informed of all client rights and receive a written copy upon request.

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RIGHT TO A PAPER COPY OF THIS NOTICE. You have the right to receive a paper copy of this or any revised Notice and/or an electronic copy by email upon request to the Privacy Officer.

RIGHT TO FILE A COMPLAINT. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the Privacy Officer listed below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW, Washington D.C. 20201 or call 1-877-696-6775. There will be no retaliation for filing a complaint.

RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES. We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

CONTACT: PRIVACY OFFICER

If you have questions about this Notice or any complaints about our privacy practices, please contact our privacy officer at:

Theresa Lynn Carter
445 East Dublin Granville Road, Worthington, OH 43085
614.844.3800 ext. 2215, tcarter@iamboundless.org.

-OR-

Report a Concern
Online: iamboundless.ethicspoint.com and
select "Make a Report"

Toll-Free Hotline: 1-844-913-0617

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We are committed to maintaining the confidentiality of your health information. Your health information may be used and disclosed for purposes of treatment, payment, and health care operations. Outside of these permitted uses, we must have your written and signed authorization unless the law permits or requires the use or disclosure without your authorization. You have the right to revoke that authorization in writing except to the extent any action has been taken in reliance on the authorization.

TREATMENT. We may use your PHI to provide you with medical treatment or services. For example, we may disclose medical information about you to doctors, psychologists, pharmacists, nurses, social workers, therapists, technicians or other personnel involved in providing services to you. Different departments of I Am Boundless, and its affiliates may also share medical information about you in order to coordinate the different services you need.

PAYMENT. We may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. Also, we may use your PHI to bill you directly for services and items, as appropriate. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

HEALTH CARE OPERATIONS. We may use and disclose your PHI to operate our business. For example, we may use personal health information to evaluate our services and the performance of our staff. We may also use personal health information for training purposes or to develop new policies, procedures, or programs that may benefit you or other individuals that we support. We may disclose your PHI to other health care providers and entities to assist in their health care operations as permitted by law.

About Boundless

Boundless is a registered trade name used by affiliated companies I Am Boundless, Inc., The Boundless Foundation, Inc., Boundless Behavioral Health, Inc., and Boundless Community Pathways, Inc.

NOTICE OF PRIVACY PRACTICES

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

EFFECTIVE: April 1, 2021

We are required by law to maintain the privacy of your protected health information ("PHI") and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. We are required to follow the practices described in this Notice. We reserve the right to change our privacy practices and the terms of this Notice at any time. If we change our Notice, we will post the revised Notice in our facilities and will have them available upon request. You can receive a copy of the current Notice at any time. This Notice describes how we have extended certain protections to your PHI and how, when, and why we may use and disclosure your PHI. With certain exceptions, we will use or disclose your PHI in the minimum necessary manner to accomplish the intended purpose of the use or disclosure. We will share PHI as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. To the extent there is stricter State or federal law regulating the privacy of your PHI, we will comply with the more strict provisions of law.

We may post this Notice or revisions on our website.
We are required by law to abide by the terms of the notice currently in effect.

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BUSINESS ASSOCIATES. It may be necessary for us to provide your health information to certain outside persons or entities that assist us with our operations, such as auditing, accreditation, legal services, etc. These business associates are required to properly safeguard the privacy of your health information.

TREATMENT ALTERNATIVES. We may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT OF YOUR CARE. We may, subject to specific limitations, disclose your PHI to family or personal representatives involved in or who help pay for your care. We also may disclose your PHI as necessary in case of an emergency. If you are able and available to agree or object, we will give you the opportunity to do so prior to making this notification. If you are unable or unavailable to agree or object, we will use our best judgement in communication with your family and personal representatives.

APPOINTMENTS, SERVICES AND FUNDRAISING. We may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate your reasonable requests, to receive communications regarding your health information from us by alternative means or at alternative locations. You may request such confidential communication by sending your written request to the Privacy Officer. We may contact you to support our fundraising efforts. You may opt-out of receiving any further fundraising communications from us by notifying our Privacy Officer at 614.844.3800 with your request to be removed from our fundraising mailing and contact lists.

THE FOLLOWING USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR AUTHORIZATION: (i) uses and disclosures for marketing purposes; (ii) uses and disclosures that constitute the sale of PHI; (iii) uses and disclosures of psychotherapy notes, as applicable; and (iv) other uses and disclosures not described in this notice.

As Required by Law. We will disclose your PHI when required to do so by federal, state or local law.

IAB may participate in health information exchanges (HIE) for the purposes of improving the overall quality of health care services provided through the coordination of care. The HIE would be responsible for implementing administrative, physical and technical safeguards to ensure the confidentiality, integrity and availability of the data it receives, creates, maintains or transmits.

SPECIAL USE AND DISCLOSURE SITUATIONS

We may use or disclose health information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out your health information without prior authorization for public health purposes, accrediting organizations, required abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donations, worker's compensation purposes, and emergencies.

We also disclose health information when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative orders.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION AND HOW TO EXERCISE YOUR RIGHTS

RESTRICTIONS ON USE AND DISCLOSURE OF INDIVIDUAL HEALTH INFORMATION. You have the right to request that we restrict how we use and disclosure your health information. You may ask us not to disclose a part of your PHI if you have paid for the services related to that treatment when we might otherwise have billed someone else for those services. You may also request that a part of your PHI not be disclosed to family members or others involved in your care. These restrictions must be made in writing to our Privacy Officer and signed by you or your representative. Any request must specify the specific restriction requested and the persons that the restriction applies to. We are not required to agree to your restrictions. We cannot agree to limit uses/disclosures that are required by law. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination. You may terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Privacy Officer.

ACCESS TO INDIVIDUAL HEALTH INFORMATION. You have the right to inspect and copy your health information. All such requests must be made in writing to our Privacy Officer and signed by you or your representative. Under some circumstances, you may not be able to review your PHI such as psychotherapy notes, records related to legal proceedings, or as otherwise restricted by law. We must make PHI available in electronic format upon request and where available. We may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.

AMENDMENTS TO INDIVIDUAL HEALTH INFORMATION. You have the right to request that your health information be amended or corrected. We will respond within 60 days unless an extension is taken. In certain cases, we may deny your request for amendment and you will be given written notice that will explain the basis and your right to appeal. You may also submit a statement of disagreement and we may prepare a rebuttal that will be provided to you. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the amendment. If we make an amendment, we may notify others who work with us and have copies of the un-amended record if we believe that such notification is necessary. You may obtain a Request for Amendment form from the Privacy Officer.

ACCOUNTING FOR DISCLOSURES OF INDIVIDUAL HEALTH INFORMATION. You have the right to receive an accounting of certain disclosures of your health information made by us after April 14, 2003. Requests must be made in writing and signed by you or your representative. Request for Accounting forms are available from the Privacy Officer. The right to receive this information is subject to certain exceptions, restrictions, and limitations. Some fees may apply.

NOTIFICATION OF BREACH. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your PHI.