Boundless Behavioral Health, Inc.
445 E. Dublin Granville Road
Worthington, OH 43085
614-844-3800
iamboundless.org

Thank you for your interest in our program. To begin the intake process you will need to complete all the forms listed below that are applicable.

- Patient Registration Form
- Financial Agreement Form
- HIPAA, Confidentiality, and Client's Rights Form
- Informed Consent for Behavioral Health Services
- Consumer Orientation Checklist
- Authorization of release information (as needed)
- Insurance card (Please provide copy)
- Guardianship (Please provide if applicable)
- Behavioral Health Services Handbook (Your copy to keep)
- Notice of Privacy Practice (Your copy to keep)

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

The Intake Department

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Registration Form

Individual Information

Name:

Address:

Cell Phone:_____
☐Can leave a detailed voicemail

Home Phone: _____
☐Can leave a detailed voicemail

Email:

Please check your primacy method of communication:

☐Verbal ☐ Sign Language ☐Written ☐Augmentative Device

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
☐Employed-Part Time ☐Student ☐Disabled-Not in Workforce
☐With Foster Parents ☐Age 0-5 ☐Other:_____

Please check the individual's race:

☐Alaskan Native ☐American Indian ☐Asian
☐White ☐Native Hawaiian or other Pacific Islander ☐African American
☐Two or More Races ☐Other Single Race ☐Unknown

Is the individual of Hispanic Origin: ☐Yes ☐No ☐Unknown
If "Yes", Please check one of the following:

☐Cuban ☐Mexican ☐Puerto Rican ☐Other Hispanic

Is the Individual a U.S. Citizen: ☐Yes ☐No

The individual's religious 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	

Medical Information

Does the individual have any handicaps (please check all that apply):

☐Deaf	☐Blind/Severe Visual Impairment	☐Developmentally Disabled
☐Non-Ambulation	☐Severe Medical Issues	

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 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	Treatment

Type of service Received (check all that apply):

☐State Hospital	☐Psychiatric Hospital	☐General Hospital
☐Outpatient	☐Residential (non-hospital)	☐Substance Abuse/Outpatient

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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

Financial Agreement and Payment Authorization

Consumer Name: _____

Boundless Behavioral Health, Inc. is committed to providing comprehensive services to each of our consumers. In order to do this we access a variety of funding sources.

The responsible party agrees to pay for any and all unpaid balances at the time services are rendered. The following are available funding sources to pay for services rendered. Not all funders may be used for services rendered. This list is of available options.

1. Commercial Insurance Carriers:

Boundless will bill most insurance carriers if proper paperwork is provided. Any outstanding balance, co-payment or deductible is due based on the insurance carrier's requirements. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from responsible parties. **Responsible parties are required to present a valid insurance card at the start of service and as needed throughout treatment.**

2. Medicaid: (Medicaid is always the last payer of resort)

Boundless is a Medicaid participating provider and will bill Medicaid accordingly for services rendered. Any outstanding balance, co-payment or deductible is due prior to an appointment. It is the responsibility of the responsible party to let Boundless know of all changes that affect the consumer's eligibility to receive Medicaid funded services which include, but are not limited to: loss of eligibility, family resources over limit, over-income requirement. **Responsible parties are required to present a valid Medicaid card at the start of service and as needed throughout treatment. Medicaid may include a monthly spend-down.**

3. Ohio Department of Education:

Boundless Center-based services utilize the Autism Scholarship Program scholarship in its entirety on an annual basis for all consumers. Boundless Outreach services utilize the ASP in its entirety or for a predetermined and agreed upon amount. Boundless will need a copy of the approval letter from the Ohio Department of Education (ODE) on an annual basis. It is the parent/guardian's responsibility to let Boundless know of all changes that may affect the consumer's scholarship fund, which include, but are not limited to: loss of scholarship, change of address, change of school district, or the addition of outside providers. If the above should occur and reduce available funds, it will be the parent/guardian's responsibility to pay the remaining balance for services rendered. It is required that parents/guardians sign each check monthly or authorize Boundless to endorse each check on your behalf.

4. Waiver: IO, Level 1, SELF

Boundless utilizes the SELF, IO and Level 1 waiver to pay for services rendered. Boundless may use any of the waivers in entirety on an annual basis or for a predetermined and agree upon amount. It is the consumer's or parent/guardian's responsibility to let Boundless know of all changes that may affect the consumer's waiver funding source, which include, but are not limited to: loss of waiver, change of address, addition of other waiver providers.

5. Private Pay: Method of Payment:

1. Cash
2. Major Credit Cards (Visa/MasterCard)
3. Personal checks (made payable to Boundless Behavioral Health)
4. Financing options for consumers who are credit worthy

6. Outstanding Balances:

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 individual parties for payment plans and strategies to help reduce your balance to assist in your continuation of treatment.

For returned checks a $35 NSF charge is applied to balance owed. If not paid according to terms, the responsible party understands that Boundless reports to an outside collection agency. In the event that an account is turned over for collection, 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.

Please provide a copy of all insurance cards at each visit. If information is not available, payment is required in full. I authorize the release of any information concerning my health car, advised, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize payment of insurance benefits otherwise payable to me, directly go to Boundless. I understand that my insurance may pay less than the actual bill for service or deem the service non-covered. I agree to be responsible for the payment of all services rendered on my behalf. I understand I am responsible for obtaining any referral authorization(s) that my insurance carrier requires. Failure to obtain necessary authorization(s) may result in non-payment of services by insurance carrier, making me responsible for all charges.

Payment Authorization

1. I authorize use of this form on all my insurance submission.
2. I authorize the release of information to my insurance company(s).
3. I authorize direct payment to my service provider.
4. I hereby permit a copy of my insurance card(s) to be used in place of the original.
5. I have supplied Boundless with a copy of my current insurance card(s).
6. I will update any changes in insurance information and address/phone number.
7. I understand any service that are provided from Boundless that are not covered by ANY insurance will be billed directly to the consumer.
8. I understand that the copay is due at the time of service.

I have read, understood and agree to the above financial policy for payment of professional fees.

_____ _____

Consumer Signature Date

_____ _____

Parent/Guardian Signature (if applicable) Date

HIPAA, Confidentiality and Clients Rights

Consumer Name: _____

CONFIDENTIALITY
All information obtained by Boundless Behavioral Health, Inc. about you or your child 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. Staff members must never, under any circumstances, mention the consumer's last name, address, or case history. Discussion of the consumer must be confined to individuals who are professionally involved with the consumer's assessment and diagnosis and/or enrollment. Any case discussions should be conducted in a professional manner and in an appropriate place, preferably behind closed doors. Consumers are never to be discussed in public. **LIMITS ON CONSUMER CONFIDENTIALITY** Boundless is responsible for the release of consumer 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

HIPAA
The signature below indicates that the consumer has received the HIPAA notice of Boundless Policies and Practices to Protect the Privacy of the consumer's health information or that the individual is the legal guardian of the consumer and has received the HIPAA notice of Boundless Policies and Practices to protect the privacy of consumers health information. Consumer Name: □ I was offered a copy of the HIPAA rights policies and declined. _____

CLIENTS RIGHTS
I have been notified about the Client's Right's, Grievance Procedure and Abuse Policies as they apply to myself and/or my child. I understand that I may request a copy at any time through the compliance department.
For Office Use Only: I have attempted to obtain the consumer's signature on the form, however was unable to due to the following circumstances:

_____ _____

Consumer Signature Date

_____ _____

Printed Name of Parent/Guardian (if applicable) Date

_____ _____

Signature Parent/Guardian Signature (if applicable) Date

Informed Consent for Assessment and Services

I understand that I am eligible to receive a range of services through Boundless Behavioral Health, Inc. The type and extent of services that I will receive will be determined following an initial assessment and through discussion with me. The goal of the assessment process is to determine the best course of treatment. I understand that treatment is a collaborative effort, with goals and objectives that are agreed upon by me and my provider.

Behavioral health treatment services available may include mental health assessment, therapy, assessment and diagnosis, psychiatry services, case management, and day treatment. I understand that services are provided based on medical necessity and I agree to participate in and receive the services, if applicable to my treatment plan. I understand that there are risks associated with treatment including: uncomfortable thoughts or feelings while working towards change; difficulty working through traumatic memories; or possible unwanted side effects of medications. I understand the benefits associated with treatment include: identifying patterns, problems, triggers, coping skills, symptoms and personal strengths; making progress, reaching goals, and decreasing symptoms; improving overall quality of life.

Speech language therapy services available may include assessment, diagnosis, treatment and consultative services. I understand that services are provided based on medical necessity and I agree to participate in and receive the services, if applicable to my treatment plan. I understand that there are risks associated with these services including: lack of progress towards goals; lack of improvement in communication skills or fine motor abilities. I understand the benefits associated with these services are: increasing communication skills in areas such as expressive language, receptive language, pragmatic language, articulation, phonology and AAC (augmentative and alternative communication).

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Occupational Therapy and Assessment services available may include assessment, diagnosis, treatment and consultative services. I understand that services are provided based on medical necessity and I agree to participate in and receive the services, if applicable to my treatment plan. I understand that there are risks associated with these services including: lack of progress towards goals; lack of improvement in communication skills or fine motor abilities. I understand the benefits associated with these services are: increasing communication skills in areas such as expressive language, receptive language, pragmatic language, articulation, phonology and AAC (augmentative and alternative communication).

Limits to Confidentiality: I understand that all information shared with the clinical staff at Boundless is confidential and that information will not be released without my consent. In most circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in specific circumstances. I further understand that there are specific and limited exceptions to this confidentiality in which Boundless staff are legally and ethically bound to report this information, which include but are not limited to the following:

- When there is a risk of imminent danger to self or another person.
- When there is suspicion that a client is being abused or neglected, is at risk for such abuse or neglect, or when abuse or neglect is reported to the staff.
- When a valid court order is issued for medical records.
- When informed of a felony crime that has been committed and not previously disclosed.

Supervision of Treatment: I understand that services may be provided by a range of health professionals, including some in training. Professionals-in-training are supervised by licensed 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 helping assure that I receive effective and ethical quality care. I may ask to meet with my treatment provider's supervisor at any time.

I understand and consent to participate in the assessment and treatment provided by Boundless. I consent to the release of information for therapeutic, billing, supervision, and other purposes in connection with my treatment between and among Boundless clinicians, staff, and service contractors who perform work on behalf of Boundless. I have read and understand the above, and I have had opportunity to ask questions about this information. I understand that I may stop treatment at any time.

Print Consumer Name	Date of Birth
Consumer Signature	Date
Parent/Guardian Signature (if applicable)	Date

Consent for Electronic Communication

Client Name: _____ Date of Birth: _____

I Am Boundless, Inc., and all of its affiliated companies, 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 I Am Boundless, Inc., 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. I Am Boundless, Inc. 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 I Am Boundless, Inc., 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 I Am Boundless, Inc., 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 I Am Boundless, Inc., 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 I Am Boundless, Inc., 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 I Am Boundless, Inc., 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 I Am Boundless, Inc. I also acknowledge that I am consenting to the use of my electronic signature on applicable documents for the purpose of service delivery by I Am Boundless, Inc., and all of its affiliated companies.

_____ _____

Print Name Date

_____ _____

Signature Date

I Am Boundless, Inc. and All Affiliated Companies

Telehealth Informed Consent Form

Client Name: _____ Date of Birth: _____

If, during the course of service delivery with I Am Boundless, Inc. (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 of client/parent/guardian Date

_____ _____

Printed name of client/parent/guardian Relationship (If applicable)

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Health History Questionnaire

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

Consumer 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 consumer had any of the following Health Problem?

Health Problems	Please check all that apply
Psychiatric	☐Developmental (Autism, Intellectual Delay) ☐Depression ☐Anxiety ☐ADHD ☐Bipolar/Mood Disorder ☐Schizophrenia ☐Eating Disorder ☐Sleep Disorder
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 consumer'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.

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 consumer had Psychiatric Hospitalizations? ☐Yes ☐No If yes, complete information below

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

Hospital	City	Date	Reason

Severity of Mental Health Associated Symptoms

Do <u>concerns related to mental health</u> 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	Date

Boundless Behavioral Health Services Handbook

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

Welcome

Boundless Behavioral Health (Step By Step Academy, Inc. aka Boundless) 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 and autism and complex behavioral health issues. Treatment is individualized and employes a strength-based approach designed to decrease the impact of their symptoms on daily functioning and increase independence.

Behavioral Health Services include:

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.

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.

Hours of Operation

Monday - Thursday 8:00 AM to 6:00 PM and Friday 8:00 AM to 5:00 PM. Additional evening hours may be available based on the availability of individual clinicians.

Boundless will be closed in recognition of the following holidays:

New Year's Day

President's Day

Memorial Day

Independence Day

Labor Day

Thanksgiving Day (Including the Friday after)

Christmas Day

Boundless Behavioral Health will also close for approximately one week around Christmas and New Year's Day (dates will vary year to year).

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 Client Rights is available in the tri-fold titled (Clients Rights) which 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:** Each visitor, staff, and individual signs a confidentiality notice. It is our practice to maintain the confidentiality of your Protected Health Information (PHI).
- **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 Service Plan and Development and Individual Participation**: It is incredibly important that the individual/guardian is actively involved in the development of the individual service plan. The development of the individual service 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 service 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 Behavioral 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 Behavioral 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.
- If there is difficulty consistently attending appointments, please touch base with the clinician or the scheduling department to reschedule the appointment and/or address about barriers to care.

- **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 or 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:	Jennifer Gannon
Location:	445 East Dublin-Granville Rd.
	Worthington, Ohio 43085
Phone:	614-436-7837 ext. 2280
Email:	jgannon@iamboundless.org
Hours:	Monday to Friday 9:00 AM to 4:00 PM

Orientation Check List

Consumer Name: _____Date: _____

☐ I affirm and have been provided an orientation to the program(s), its staff and its service(s) Including each of the following areas listed below:

☐Center-Based ☐Behavioral Health Counseling ☐Pharmacological ☐Case Management

☐Speech ☐Outreach- Home Team ☐Outreach – Parent Training ☐Outreach- Behavioral Consultation

☐Waiver Services ☐ Other please specify _____

Orientation is provided on the following topics and is documented in the Boundless Behavioral, Education and Outreach Handbooks. Orientation can be provided over time with various staff. Additional information may be provided up request. If you have any additional questions, please touch base with your primary clinician.

1. Consumer Fee explanation, Financial Arrangement, fees, obligations
2. Confidentiality
3. Clients Rights and Responsibilities
4. Purpose and Process of assessment
5. Person-Centered Plan and development and consumer participation
6. Ways in which consumer 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

_____ _____

Consumer Signature Date

_____ _____

Parent/Guardian Signature (If applicable) Date

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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. The 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

RV 2/11/2020

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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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. The 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

RV 2/11/2020

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.

Notice of Boundless Policies and Practices to Protect the Privacy of Consumer's Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGY AND MEDICAL INFORMATION ABOUT CONSUMERS MAY BE USED AND DISCLOSED AND HOW THIS INFORAMTION CAN BE ACCESSED. PLEASE REVIEW IT CAREFULLY

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

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

A. "*PHI*" refers to information in the clinical record that could identify a consumer.
B. "*Treatment*, *Payment, and Health Care Operations"*
    1. *Treatment* is when we provide, coordinate or manage consumer's health care and other services related to their health care. An example of treatment would be when we consult with another heath care provider.
    2. *Payment* is when we obtain reimbursement for consumer's healthcare. Example of payment are when we disclose PHI to a health insurer to obtain reimbursement for consumer's health care or to determine eligibility or coverage.
    3. *Health Care Operations* are activities that relate to the performance and operation of our programs. Examples of health care operations are quality assessment and improvements activities, business-related matters such as audits and administrative services, and case management and care coordination.

II. Uses and Disclosures Requiring Authorization

A. We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purpose outside of treatment, payment and health care operations, we will obtain an authorization from the legal guardian before releasing this information.
B. We will also need to obtain an authorization before releasing any psychotherapy notes. "*Psychotherapy notes"* are notes made about conversation during a private, group, join, or family counseling session between a consumer and a psychologist, which are kept separate from the rest of the clinical record. These notes are given a greater degree of protection the PHI.
C. A legal guardian may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. An authorization may not be revoked to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances.

A. *Child Abuse*: If, in our professional capacity, we know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, we are required by law to immediately report that knowledge or suspicion to the Ohio Public Children Service Agency, or municipal or county peace officer.

B. *Adult and Domestic Abuse*: If we have reasonable cause to believe that an elder adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect or exploitation, we are required by law to immediately report such belief to the County Department of Job and Family Services.

C. *Judicial or Administrative Proceedings*: If a consumer is involved in a court proceeding and a request is made or information about evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release this information without written authorization from the consumer or the legal guardian or by a court order. The privilege does not apply when the consumer is being evaluated for a third party or where the evaluation is court order. The legal guardian of the consumer will be informed in advance if this is the case.