Intensive Outpatient Program (IOP) **Client Agreement**

Welcome! As a participant in Astra Behavioral Health's **Virtual IOP**, you will be able to learn strategies to better manage pain, recovery from chemical dependency, and mental health difficulties that often make day-to-day life incredibly challenging. We at Astra want to take a team approach to help you better engage in life.

Here is a brief description of team members that could be involved:

- ***Therapist:*** works with participants in group, individual, and family counseling.
- ***Psychiatrist/Nurse Practitioner:*** works with participants to monitor and manage any psychiatric medications deemed appropriate.
- ***Primary Care Physician:*** will be informed of your participation via letter and encouraged to communicate as part of the treatment team as appropriate.
- ***Peer Support Specialist:*** if eligible, you may be referred for additional support in your recovery.
- ***Targeted Case Management:*** if eligible, this service is highly recommended to assist you in obtaining needed resources and goal-setting.
- ***You:*** as the most essential part of your treatment, you will need to put effort into your treatment and implement new strategies into your life.

Please review the following as it is important that you understand the kinds of services you will be provided and the terms and conditions under which these services will be offered.

I, _____, am requesting treatment from the staff of Astra Behavioral Health. As a condition of that treatment, I acknowledge the following items and agree to them. **(Please initial each item)**

I understand:

_____ 1. The staff believes that the outpatient treatment strategies the program uses provides a useful intervention for dual-diagnosis (chemical dependency and mental illness) problems as well as assistance in nonpharmacological pain management; however, no specific outcome can be guaranteed.

_____2. Treatment participation requires some basic ground rules. These conditions are essential for a successful treatment experience. Violation of these rules can result in treatment termination.

Intensive Outpatient Program (IOP) **Client Agreement**

I agree to the following: **(Please initial each item)**

_____ a. It is necessary to be on time for appointments. During the duration of the IOP Program, I may be called upon to complete a mandatory Urine Drug Screen.

_____b. Conditions of treatment require **abstinence from all drug and alcohol use for the entire duration of the treatment program.** If I am unable to make this commitment, I will discuss other treatment options with the program staff.

_____ c. I will discuss any drug or alcohol use with staff and group while in treatment.

_____ d. Treatment consists of individual and group sessions. Individual appointments can be rescheduled, if necessary. **I understand that I am required to attend two (2) groups minimal per week, while enrolled into IOP. I also understand that if I miss six (6) consecutive groups that I will be discharged from the program.** I understand that group appointments cannot be rescheduled and attendance is extremely important. I will notify my counselor in advance if I am going to miss a group session. Telephone notification may be made for last-minute absences or lateness.

_____ e. Treatment will be terminated if I attempt to sell drugs or encourage drug use by other clients.

_____ f. I understand that graphic stories of drug or alcohol use will not be allowed.

_____ g. I agree not to become involved romantically or sexually with other clients.

_____ h. I understand that it is not advisable to be involved in any business transactions with other clients.

_____ i. I understand that all matters discussed in group session and the identity of all group members are absolutely confidential. I will not share this information with nonmembers.

_____ j. All treatment is voluntary. If I decide to terminate treatment, I will discuss the decision with the staff.

_____ k. I understand that I may be recommended to a higher level of care if I am having suicidal and homicidal thoughts/feelings.

_____ 3. Staff: Services are provided by psychologist, licensed marriage and family counselors, master's level counselors-in-training, or other certified addiction staff people. All non-licensed counselors are supervised by a licensed counselor trained in treatment of addictions.

_____4. Consent to Videotape/Audiotape: To help ensure the high quality of services provided by the program, therapy session may be audiotaped or videotaped for training purposes. The client and, if applicable, the client's family consents to observe, audiotaping, and videotaping.

_____5. Confidentiality: All information disclosed in these sessions is strictly confidential and may not be revealed to anyone outside the program staff without the written permission of the client or the client's family. The only expectations are when disclosures are requires or permitted by law. Those situations typically involve substantial risk of physical harm to self or other or suspected abuse of children or the elderly.

_____ 6. Accomplishing treatment goals requires the cooperation and active participation of clients and their families. Very rarely, lack of cooperation by a client may interfere substantially with the program's ability to render services effectively to the client or to others. Under such circumstances, the program may discontinue services to the client.

Intensive Outpatient Program (IOP) **Client Agreement**

Service Agreement and Consent

I certify that I have read, understand, and accept this Service Agreement and consent. This agreement and consent covers the length of time I am involved in treatment activities at this facility.

Client's Signature: _____ Date:_____

Witness Signature: _____ Date: _____

Intensive Outpatient Program (IOP) **Group Rules**

- Group participants are expected to be on-time for group sessions. Should you need to use the restroom during group, please inform the group therapist.

- Should you be unable to attend programming, please call and inform staff as soon as possible.

- Group members are expected to keep what is shared in the group confidential. This means not talking about what is shared in the group outside of group and not talking about other group member's experiences. Staff members are bound by privacy laws to keep information confidential. However, there are requirements by law for certain safety issues to be reported or acted upon (threat of harm to self/others, child/vulnerable adult abuse/neglect, alcohol/substance use).

- Respect for others is expected from all participants. This includes allowing other to express themselves in session, listening to others without giving unprompted advice, speaking for yourself and not others, and maintaining appropriate boundaries (e.g. not use derogatory/aggressive language towards others, keep distance from other and not invade personal space, ect.)

I have read and understand the rules as stated above.

_____ _____

Client's Signature Date

_____ _____

Staff Witness Signature Date

PATIENT: _____

DOB: _____ DATE: _____

Physical Health Status Questionnaire

History of medical problems

1. Problems with eyes, ears, nose, throat? ☐ Yes ☐ No
   If yes, please explain:_____
2. Dizziness, fainting, headache, fatigue, seizures, head injuries? ☐ Yes ☐ No
   If yes, please explain:_____
3. Chest pains, high blood pressure, heart attack, stroke, heart problem, blood disease, hardening of the arteries? ☐ Yes ☐ No
   If yes, please explain:_____
4. Cough, shortness of breath, COPD, tuberculosis (TB) or any other respiratory problems? ☐ Yes ☐ No
   If yes, please explain:_____
5. Problems with thyroid, pancreases, liver, or jaundice? ☐ Yes ☐ No
   If yes, please explain:_____
6. Ulcers or other stomach or bowel problems? ☐ Yes ☐ No
   If yes, please explain:_____
7. Disorders of the muscles, bones, back, joints or arthritis? ☐ Yes ☐ No
   If yes, please explain:_____
8. Any environmental or food allergies? ☐ Yes ☐ No
   If yes, please explain:_____
9. Are you pregnant? ☐ Yes ☐ No
   If yes, please explain:_____
10. Any infectious or contagious diseases (TB, hepatitis, HIV, etc.)? ☐ Yes ☐ No
    If yes, please explain:_____
11. Do you smoke, use vapor products or smokeless tobacco? How much per day? ☐ Yes ☐ No
    If yes, please explain:_____
12. Have you ever had blackouts or DT's? ☐ Yes ☐ No
    If yes, please explain:_____
13. Have you ever been hospitalized? Had any major surgeries? How long ago? ☐ Yes ☐ No
    If yes, please explain:_____

14. Have you had family members with any psychiatric/substance use disorder, or other major illness? ☐ Yes ☐ No

If yes, please explain:_____

15. How many hours a day do you sleep? Do you use a sleep aid? ☐ Yes ☐ No

If yes, please explain:_____

16. Are you on a special diet? ☐ Yes ☐ No

If yes, please explain:_____

17. Are there any recent changes to your diet? ☐ Yes ☐ No

If yes, please explain:_____

18. Are you allergic to any medications? ☐ Yes ☐ No

If yes, please explain:_____

19. Date of your last physical exam: _____ 20. Date of your last dental exam:_____

Patient Signature: _____ **Date:** _____

For Evaluator to Complete

Is there a medical concern that would hinder patient's ability to participate in treatment/IOP? ◯ Yes ◯ No

If yes, please describe:

_____

Does the patient need to be referred to medical assistance? ◯ Yes ◯ No

If yes, please describe:

_____

Evaluator Signature: _____ Date: _____

Astra Behavioral Health, LLC

INTAKE FORMS

RETURN THIS FORM

OFFICE USE: _____

Pages 1-6 must be emailed or submitted back to Astra BH once completed

DEMOGRAPHICS

FIRST NAME			MI
LAST NAME			
DOB	AGE	LANGUAGE	
SSN		RACE/ETHNICITY	
SEX		PREFERRED PRONOUN	
MARITAL STATUS		NAME OF SPOUSE	
SCHOOL		GRADE	
EMPLOYER		EMPLOYER PHONE #	

CONTACT INFORMATION

PREFERRED NAME			
CELL PHONE			
HOME PHONE			
PREFERRED PHONE NUMBER ☐ HOME ☐ CELL			
EMAIL			
ADDRESS			
CITY	STATE	ZIP	
APPOINTMENT REMINDER: ☐ TEXT ☐ CALL ☐ EMAIL			

PARENT/GUARDIAN 1

RELATION			
LAST	FIRST		MI
DOB	PHONE		
ADDRESS			
CITY	STATE	ZIP	
DOES PATIENT RESIDE WITH GUARDIAN 1? ☐ YES ☐ NO			

PARENT/GUARDIAN 2

RELATION			
LAST	FIRST		MI
DOB	PHONE		
ADDRESS			
CITY	STATE	ZIP	
DOES PATIENT RESIDE WITH GUARDIAN 2? ☐ YES ☐ NO			

HEALTH INSURANCE INFORMATION

IS YOUR APPOINTMENT COURT-ORDERED?	☐ YES	☐ NO
IS YOUR APPOINTMENT RELATED TO WORKERS COMP?	☐ YES	☐ NO
DO YOU HAVE AN EMPLOYEE ASSISTANCE PROGRAM (EAP)?	☐ YES	☐ NO

PRIMARY INSURANCE

INSURANCE COMPANY			
POLICY #		GROUP #	
SUBSCRIBER NAME			
DOB	SSN		
SUBSCRIBER ADDRESS			
CITY	STATE	ZIP	

SECONDARY INSURANCE

INSURANCE COMPANY			
POLICY #		GROUP #	
SUBSCRIBER NAME			
DOB	SSN		
SUBSCRIBER ADDRESS			
CITY	STATE	ZIP	

I hereby authorize payment of medical benefits billed to my insurance by ASTRA BH. I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I agree to provide ASTRA BH with the most current and up-to-date insurance(s) information within 30 DAYS of any changes to my insurance information; to include losing insurance and transitioning into a self-pay status. I accept responsibility for fees that exceed the payment made by my insurance, and/or if ASTRA BH or the provider do not participate with my insurance. I hereby authorize ASTRA BH to use and/or disclose my health information, which specifically identities me or which can reasonably be used to identify me, to carry out my treatment, payment, and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, the ASTRA BH can refuse to treat me. I understand this authorization can only be revoked in writing. If I revoke my consent, such revocation will not affect any actions that ASTRA BH provider took before receiving my revocation.

X	SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE	DATE

PATIENT NAME:	DOB:

MEDICAL INFORMATION

MEDICAL CONDITIONS

CURRENTLY PRESCRIBED MEDICATIONS

MEDICATION	DOSAGE
MEDICATION	DOSAGE
MEDICATION	DOSAGE
MEDICATION	DOSAGE
MEDICATION	DOSAGE

HOSPITALIZATIONS ☐NONE

FACILITY	DATE
FACILITY	DATE
FACILITY	DATE

ALLERGIES ☐NONE

EXTERNAL PROVIDER INFORMATION

PHARMACY	PHONE	
ADDRESS		
CITY	STATE	ZIP
PRIMARY CARE PROVIDER	PHONE	
ADDRESS		
CITY	STATE	ZIP

EMERGENCY CONTACT	RELATION	
PHONE 1		
PHONE 2		
MENTAL HEALTH PROVIDER	PHONE	
ADDRESS		
CITY	STATE	ZIP

OTHER

ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING?	☐YES	☐NO
DO YOU USE RECREATIONAL DRUGS OR ALCOHOL?	☐YES	☐NO
ARE YOU SEEKING TREATMENT FOR SUBSTANCE USE?	☐YES	☐NO
HAVE YOU RECEIVED GENETIC TESTING?	☐YES	☐NO
IF SO, WHERE WAS THE GENETIC TESTING DONE? _____		

PATIENT INDICATED EXCEPTIONS TO THE DISCLOSURE OF PHI

PLEASE LIST PERSONS THAT MAY ACCESS YOUR HEALTH INFORMATION ON YOUR BEHALF

NAME	RELATION	☐ SCHEDULE/CANCEL APPOINTMENTS	☐ PICK UP PRESCRIPTIONS	☐ SPEAK TO PROVIDER
NAME	RELATION	☐ SCHEDULE/CANCEL APPOINTMENTS	☐ PICK UP PRESCRIPTIONS	☐ SPEAK TO PROVIDER
NAME	RELATION	☐ SCHEDULE/CANCEL APPOINTMENTS	☐ PICK UP PRESCRIPTIONS	☐ SPEAK TO PROVIDER

PATIENT NAME:	DOB:

AUTHORIZATION FOR OUTPATIENT TREATMENT

My signature affixed below acknowledges I wish to have treatment given to me, my child, or my ward by Astra Behavioral Health, LLC. Further, my signature affirms I have been informed of the treatment and procedures necessary, which will be performed by a psychiatrist, psychiatric nurse practitioner, therapist, and/or assisted by other staff members of Astra Behavioral Health, LLC; and my authorization to receive such treatment and procedures is hereby granted.

X SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE	DATE

INFORMED CONSENT FOR TELEHEALTH SERVICES

My signature affixed below affirms I understand the following:

1. I understand that I have a right to withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment.
2. I understand that if the provider believes I would be better served by a traditional face-to-face encounter, the provider may, at any time, stop the telehealth visit and schedule a face-to-face visit. Therefore, I understand that technology problems may necessitate an in-person visit.
3. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
4. I understand that the laws that protect the privacy and confidentiality of medical information also apply to telehealth.
5. I understand that I will be responsible for any copayments or coinsurances that apply.

X SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE	DATE

ACKNOWLEDGEMENT OF RECEIPT OF FORMS

FORM	ACKNOWLEDGED RECEIPT
1. CLIENT PAYMENT PROGRAMS AND FEE AGREEMENT	(INITIAL) X _____
2. CONFIDENTIALITY OF CLIENT RECORDS	(INITIAL) X _____
3. NOTICE OF CLIENT RIGHTS	(INITIAL) X _____
4. VIDEO MONITORING PRACTICES	(INITIAL) X _____
5. PATIENT RESPONSIBILITIES	(INITIAL) X _____
6. LATE CANCELLATION/NO SHOW POLICY	(INITIAL) X _____
7. NOTICE OF PRIVACY PRACTICES	(INITIAL) X _____
8. YOUR INDIVIDUAL PRIVACY RIGHTS UNDER HIPAA	(INITIAL) X _____

My initial by the name of each individually listed document and my signature affixed below affirms that I have received, read, fully understand, and agree to the contents of each document and, should I have any questions, I will ask a staff member of Astra Behavioral Health, LLC.

X SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE	DATE

PATIENT NAME:	**DOB:**

RESOURCES

At Astra Behavioral Health, we are committed to providing the best resources to meet your mental health needs. We understand that there are often challenges and we are here to help. To get started,

Please choose "Y" or "N" to the following questions:	**Y**	**N**
Are you in need of resources, such as housing, clothing, education, food, and more?	☐	☐
Do you need assistance with employment?	☐	☐
Do you have transportation issues?	☐	☐
Do you need assistance with benefits, such as food stamps, SSI, SSDI, KTAP, or insurance?	☐	☐
Would you like help with finding community activities for yourself and your family?	☐	☐
Have you experienced alcohol or drug problems within the past year?	☐	☐
Are you having trouble accessing medical care?	☐	☐
Are you getting overwhelmed?	☐	☐

We can provide strength, hope, resources, and skills in these areas through Targeted Case Management, Supported Employment, and Peer Support services. If you answered "Y" to any of these questions, we will contact you to assist in getting the help you need.

IF PATIENT IS A MINOR

Please answer the following questions so that we may be able to provide the best resources for your needs. We understand that there are often challenges and we are here to help.

Please choose "Y" or "N" to the following questions:	**Y**	**N**
Has your child ever engaged in self-injury, a pattern of reckless decisions, had an eating disorder, or threatened or attempted suicide?	☐	☐
Does your child have trouble making friends or communicating with children their own age?	☐	☐
Is there a current or previous court or child protective services involvement regarding this child?	☐	☐
Are you struggling to manage your child's behavior at home?	☐	☐
Is your child having behavior issues at school or struggling academically (failing classes)?	☐	☐
Does your child engage in dangerous behaviors (violence/fighting, damaging property, leaving home without permission, fire-setting, etc.?)	☐	☐
Does your child follow rules/laws? (at home, school)?	☐	☐
To the best of your knowledge, has your child ever used drugs, alcohol, tobacco products, or other illegal products?	☐	☐
Has your child had a psychiatric hospitalization within the past 12 months?	☐	☐
Do you have any other concerns regarding your child that are not listed here?	☐	☐

If so, please explain: _____

RETURN THIS FORM TO TARGETED CASE MANAGEMENT/SUPPORTED EMPLOYMENT

Do you consent for your confidential information to be released to your PRIMARY CARE PHYSICIAN? ◯ YES ◯ NO

If you have answered yes to the above question, please complete the following form. Otherwise, please skip this page.

PATIENT NAME:	DOB:	SSN:

**Complete the following only if the person authorizing the use or disclosure is not the patient:

Representative's Name	Relationship to Patient	Legal Authority

Disclosure of the patient's PHI	FROM	Disclosure of the patient's PHI	TO
Person, class of persons, or organization **Astra Behavioral Health, LLC**		**Primary Care Physician**	
1013 Granite Drive **Bardstown, KY 40004** **T: (502) 349-3100 F: (502) 349-3169** ☐	**2000 Ring Road** **Elizabethtown, KY 42701** **T: (270) 506-2730 F: (270) 900-0704** ☐	**Address**	
129 Parkway Drive **Bardstown KY, 40004** **T: (502) 233-9696 F: (502) 373-1648** ☐	**420 N Loretto Road Ste 200** **Lebanon, KY 40033** **T: (270) 321-4480 F: (270) 321-4490** ☐	**City** / **State** / **ZIP**	
		Phone	**Fax**

THE FOLLOWING PROTECTED HEALTH INFORMATION MAY BE DISCLOSED:

☐ Entire Medical Record	☐ Other (specify below)
☐ Any Written/Verbal Communication	

FURTHER, I AUTHORIZE THE DISCLOSURE OF THE FOLLOWING PROTECTED HEALTH INFORMATION:

☐ Mental Health	☐ Substance Abuse	☐ Records created by non-ABH providers

THE PURPOSE OF THE DISCLOSURE IS:

☐ Continuity of Care	☐ Insurance Purposes	☐ Legal Circumstances
☐ Individual Elects to Not State Purpose	☐ Other:	

I understand that pursuant to KRS 304.17A-555-Patient's Right of Privacy Regarding Mental Health or Chemical Dependency-Authorized Disclosure, my protected health information, used and/or shared under this authorization may not be shared again by the recipient of the information beyond the purpose for which my authorization was given without first obtaining my specific written consent to re-disclose. Additionally, I understand that my information prohibits the recipient to further disclose any information without written consent unless otherwise permitted by Federal Law 42 CFR Part 2. I am aware that if the person or entity that receives this information is not a healthcare provider or plan covered by federal privacy regulations, this information may be re-disclosed and no longer be protected by these regulations.

I understand that medical records released pursuant to this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions and/or blood borne infectious diseases, which are subject to federal and/or state restrictions on disclosure. The federal regulations restrict any use of protected health information to criminally investigate or prosecute any alcohol and/or substance use patients.

I understand I have the right to revoke this authorization in writing to an Astra Behavioral Health location listed above at any time with the exception that the revocation will not apply to information already released in response to this authorization. Furthermore, per 94 HC250, I am entitled to one (1) free copy of my medical record. Additional requests may be subject to fees. I understand that in any and all authorized releases of information, the "minimum necessary" rule will apply. I understand that my signature on this form will not affect my condition for treatment, payment, enrollment or eligibility pertaining to benefits.

This authorization automatically expires one (1) year from the date signed unless otherwise specified:	**EXP DATE**
MY SIGNATURE AFFIXED BELOW AFFIRMS THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND CONSENT TO THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSE STATED ABOVE	
SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE	**DATE**
RELATIONSHIP TO PATIENT (IF REPRESENTATIVE)	**WITNESS SIGNATURE**

Do you consent for your confidential information to be released to OTHER BEHAVIORAL HEALTH PROVIDERS? ◯YES ◯NO

If you have answered yes to the above question, please complete the following form. Otherwise, please skip this page.

PATIENT NAME:	DOB:	SSN:

**Complete the following only if the person authorizing the use or disclosure is not the patient:

Representative's Name	Relationship to Patient	Legal Authority

Disclosure of the patient's PHI	FROM	Disclosure of the patient's PHI	TO
Person, class of persons, or organization **Astra Behavioral Health, LLC**		Behavioral Health Provider	
1013 Granite Drive ☐ Bardstown, KY 40004 T: (502) 349-3100 F: (502) 349-3169	2000 Ring Road ☐ Elizabethtown, KY 42701 T: (270) 506-2730 F: (270) 900-0704	Address	
129 Parkway Drive ☐ Bardstown KY, 40004 T: (502) 233-9696 F: (502) 373-1648	420 N Loretto Road Ste 200 ☐ Lebanon, KY 40033 T: (270) 321-4480 F: (270) 321-4490	City / State / ZIP	
		Phone / Fax	

THE FOLLOWING PROTECTED HEALTH INFORMATION MAY BE DISCLOSED:

☐ Entire Medical Record	☐ Other (specify below)
☐ Any Written/Verbal Communication	

FURTHER, I AUTHORIZE THE DISCLOSURE OF THE FOLLOWING PROTECTED HEALTH INFORMATION:

☐ Mental Health	☐ Substance Abuse	☐ Records created by non-ABH providers

THE PURPOSE OF THE DISCLOSURE IS:

☐ Continuity of Care	☐ Insurance Purposes	☐ Legal Circumstances
☐ Individual Elects to Not State Purpose	☐ Other:	

I understand that pursuant to KRS 304.17A-555-Patient's Right of Privacy Regarding Mental Health or Chemical Dependency-Authorized Disclosure, my protected health information, used and/or shared under this authorization may not be shared again by the recipient of the information beyond the purpose for which my authorization was given without first obtaining my specific written consent to re-disclose. Additionally, I understand that my information prohibits the recipient to further disclose any information without written consent unless otherwise permitted by Federal Law 42 CFR Part 2. I am aware that if the person or entity that receives this information is not a healthcare provider or plan covered by federal privacy regulations, this information may be re-disclosed and no longer be protected by these regulations.

I understand that medical records released pursuant to this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions and/or blood borne infectious diseases, which are subject to federal and/or state restrictions on disclosure. The federal regulations restrict any use of protected health information to criminally investigate or prosecute any alcohol and/or substance use patients.

I understand I have the right to revoke this authorization in writing to an Astra Behavioral Health location listed above at any time with the exception that the revocation will not apply to information already released in response to this authorization. Furthermore, per 94 HC250, I am entitled to one (1) free copy of my medical record. Additional requests may be subject to fees. I understand that in any and all authorized releases of information, the "minimum necessary" rule will apply. I understand that my signature on this form will not affect my condition for treatment, payment, enrollment or eligibility pertaining to benefits.

This authorization automatically expires one (1) year from the date signed unless otherwise specified:	**EXP DATE**
MY SIGNATURE AFFIXED BELOW AFFIRMS THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND CONSENT TO THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSE STATED ABOVE	
SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE	**DATE**
RELATIONSHIP TO PATIENT (IF REPRESENTATIVE)	**WITNESS SIGNATURE**

CLIENT PAYMENT PROGRAMS

Astra Behavioral Health Sliding Fee Scale Program - This program is for individuals who are without health insurance coverage and may need assistance to fulfill their financial obligation to Astra Behavioral Health. Please request and complete a Sliding Scale Fee Application so that we can assist you.

Astra Behavioral Health Financial Assistance Program - This program is for individuals with health insurance but may require assistance to pay their out-of-pocket expenses in-full on a timely basis. Please contact us early to set up payment arrangements and to possibly avoid your account balance being referred to a collection agency. Please see the payment arrangement schedule below. If you are financially unable to make payment arrangements according to our fee schedule, it is your responsibility to contact our Billing Office to make other financial payment arrangements within 10 days of receiving a statement from us at (270) 506-2730.

FEE AGREEMENT

As a patient of Astra Behavioral Health, LLC, I certify the information given by me is correct and by signing the accompanying material confirmation form, I affirm my acceptance of full responsibility for all charges incurred. Further, I consent to the billing of my insurance company, whose accurate information I have provided, for services rendered to me by Astra Behavioral Health, LLC. I authorize Astra Behavioral Health, LLC to furnish information from my medical record to my insurer. By signing the accompanying material confirmation form, I hereby assign and authorize payment from my insurer directly to Astra Behavioral Health, LLC for all charges incurred for received treatment and services.

Fee schedule for services is listed below:

Initial Eval with MD or ARPN: $195.00	Initial Therapist Visit: $175.00
15 Minute follow up visit with MD or APRN: $90.00	30 Minute Therapist Visit: $75.00
30 Minute follow up visit with MD or APRN: $125.00	45 Minute Therapy Session: $100.00
Intensive Outpatient Program: $150.00/day	60 Minute Therapy Session: $150.00
Peer Support: $10.00/unit	Targeted Case Management: $350.00
Urine Drug Screen: $50.00	Targeted Case Management CC: $550.00

Charges for services are based on the usual, customary, and reasonable fee for the area. A charge list is available upon request. All payments are required at the time of service. As a patient of Astra Behavioral Health, LLC, I agree to pay any self-pay, deductible and/or co-insurance (if applicable) at the time of each visit.

I understand that in the event of my insurance company's denial of payment for my services, I am responsible for the fee within thirty (30) days from denial. I understand I am responsible for any balance after insurance payments have been made, including all charges incurred in collecting these amounts if the account becomes delinquent – such as court costs, collection agency commission, charges and/or attorney fees.

For Medicare patients: I certify that the information provided by me in applying for payment under title XV of the Social Security Act is correct. I authorize Astra Behavioral Health, LLC to release to the Social Security Administration, or its carriers, any medical information form my record to assist in the processing of my insurance claims for services rendered. I request that payment be made directly to Astra Behavioral Health, LLC.

CONFIDENTIALITY OF PATIENT RECORDS

Confidentiality of your records maintained by this office is protected by Federal Law and Regulations. Generally, we may not say to a person outside this facility that you are a client here unless:

1. You consent in writing
2. You present a danger to yourself or others
3. Disclosure is required by court order or subpoenas
4. Your treatment is ordered by or is under court supervision
5. There is suspected physical or sexual abuse or neglect of a child or adult
6. Disclosure is made to medical personnel in a medical emergency or to qualified personnel for audit or program evaluation
7. Insurance must verify treatment before covering charges

(See 42 U.S.C. 290dd-3 and 42 U.S.C 290ee-3 for Federal Laws and 42 CFR Part 2 for Federal Regulations)

NOTICE OF CLIENT RIGHTS

As a client of Astra Behavioral Health, you have the following rights:

1. To be treated with dignity, respect, and consideration.
2. To not be discriminated against in determining eligibility for treatment.
3. To be informed of the services offered to you and offer consent to receive those services in writing. To be involved in treatment planning and any case management plans for your care.
4. To be informed of the content of treatment and case management plans.
5. To receive treatment that is based on your individual needs.
6. To give written informed consent to participate in a research study.
7. To have your protected health information be kept confidential as according to legal regulations.
8. To request a written statement of service charges and be informed of the policy for the assessment and payment of fees.
9. To be informed of the rules of client conduct, including the consequences for the use of alcohol and other drugs or other infractions that may result in disciplinary action or discharge.
10. To be informed of information in your record.
11. To receive one free copy of your record.

ACKNOWLEDGMENT OF VIDEO MONITORING PROCEDURES

Astra Behavioral Health, LLC utilizes a video camera as a necessary precaution to treatment. To promote the safety of all patients and staff, there may be times when the patient is being monitored by video camera, however, audio is not recorded. Also, please note the bathroom areas are not monitored. As a patient of Astra Behavioral Health, LLC, you must be aware of these video monitoring procedures.

PATIENT RESPONSIBILITIES

Patients of Astra Behavioral Health, LLC assume certain responsibilities

1. The patient is responsible for providing information about their health, past illness, hospital stays and all use of medication. The patient is responsible for asking questions when information or instruction provided by a staff member of Astra Behavioral Health, LLC is not fully understood. If the patient feels they are unable to continue with treatment, the patient is responsible for informing their provider.
2. Your health depends not only on care provided by this facility, but also on the decisions one makes in their daily life. The patient is responsible for recognizing the effects of their lifestyle on their health.
3. The patient, and anyone accompanying the patient, is responsible for being considerate of needs of other patients and staff members.
4. The patient is responsible for providing current and correct insurance information and for working with us for payment of services received.
5. The patient is responsible for adherence to the Cancellation/No Show policy of Astra Behavioral Health

LATE CANCELLATION/NO SHOW POLICY

Our goal is to provide quality individualized medical care in a timely manner. No-shows, late arrivals, and late cancellations inconvenience those individuals who need access to care. A "no show" is a scheduled but missed appointment. A "late cancellation" is an appointment cancelled with less than 24 hours of notice. A "late arrival" is an arrival to an appointment at a time that is past the scheduled time.

To be respectful of the medical needs of other patients, please be courteous and promptly call our office if you are unable to attend an appointment. This time will be reallocated to another patient in need of treatment. If it is necessary to cancel your scheduled, we require that you call at least 24 hours in advance. We understand that there are times when you must miss an appointment due to emergencies or other unavoidable obligations, however, when you do not call to cancel an appointment, you may be preventing another patient from receiving care.

Please cancel at least 24 hours in advance. Two (2) or more no-shows and or late cancels in a six (6) month period may result in a discharge from the practice and thus a denial of scheduling any future appointments.

If you arrive fifteen (15) minutes past your scheduled appointment time, your receipt of services is dependent on the given day's availability, accommodations made at the end of the day, or the rescheduling of your appointment.

Due to the large block of time required for psychiatric evaluations, the late cancellation or no show of such an appointment may result in your inability to reschedule. Further, failure to confirm evaluations at least 24 hours in advance may result in forfeiture of your scheduled appointment time.

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully.***

Our Duty to Protect Your Privacy

Your health information is personal. ASTRA Behavioral Health, LLC is legally required to protect the privacy of your data. It does so in all aspects of its business. ASTRA Behavioral Health, LLC has policies in place about protecting the privacy of your data. These policies comply with state and federal laws. ASTRA Behavioral Health, LLC uses and gives out your health information only where required by law or where necessary for business.

Where Do I Send Questions or Requests?

To submit questions about your privacy rights or submit a written request.

ASTRA Behavioral Health, LLC
ATTN: Compliance Officer
2000 Ring Road
Elizabethtown, KY 42701

What Type of Information does ASTRA Behavioral Health, LLC Have?

The Department for Community Based Services (DCBS) or Social Security Administration (SSA) for Supplemental Security Income (SSI) approved you for Medicaid. DCBS and SSA send your information to ASTRA Behavioral Health, LLC. Information sent includes:

- Your individual information including name, address, phone number, date of birth, social security number, eligibility program information, Medicaid number.
- Information on other health insurance policies you may have.
- Your medical records (if necessary).
- Your providers claim for your services. Provider claims contain information on your treatment given.

ASTRA Behavioral Health, LLC is Required to:

- Follow the terms of this notice
- Support your privacy rights under the law
- Give you a paper copy of this privacy notices and post it on our website
- Mail out a new notice if our privacy practices change
- Treat your data as confidential by not using or giving out your information without your written permission, except to support normal business or under the allowable circumstances given in this notice
- Tell you what types of information we collect on you
- Release your health information without your permission in the event of an emergency. The release of your data must be in your best interest.
- Follow state laws regarding the release of your data in the instances where state law provides stronger protection of your data than the HIPAA law.

How ASTRA Behavioral Health, LLC May Use of Give Out Your Information

ASTRA Behavioral Health, LLC can use and give out your information without an authorization (special permission from you) for our normal business and where required by law. This document tells you of some of the ways this can occur. All the way ASTRA Behavioral Health, LLC may use and give out your information without your express permission will fall within one of the groups listed below.

Data for Treatment and Payment Purposes

ASTRA Behavioral Health, LLC, and businesses we work with receive/give out your mental health information for:

- The coordination of your treatment with medical professionals and facilities
- The billing and payment of your claims
- The review of your care and use of benefits
- The prior authorization of your requested services

Data exchanged for your treatment and claim payment involves communications between your providers, ASTRA Behavioral Health, LLC, your insurance carriers, and other organizations necessary to receive, review, approve, process, and successfully pay for your mental health care claims.

Data for Health Care Operations

ASTRA Behavioral Health, LLC may use and disclose your information to carry out insurance-related activities related to its operations. Activities may include:

- Submitting claims to other insurance companies
- Conducting or arranging for medical review for certain medical/mental problems you may be experiencing
- Legal services
- Audit services
- Fraud and abuse detection programs
- Business planning, management, and general administration

Case and Utilization Management

ASTRA Behavioral Health, LLC may use your mental health medical information to approve services. We may give out information to others who must make decisions about your care.

Other Allowable Uses of Your Health Information Without Permission (Authorization)

- **Public Health**: We may give your data to public health agencies to prevent or control disease, injury, or disability; reporting child abuse or neglect; and reporting domestic violence. ASTRA Behavioral Health, LLC may also report your data to the Food and Drug Administration (FDA) to notify them of problems with products and reactions to medications.
- **Coroners, Medical Examiners, and Funeral Directors**: ASTRA Behavioral Health, LLC may give your protected health information to coroners, medical examiners and funeral directors if needed.
- **Public Safety**: ASTRA Behavioral Health, LLC may give your data to prevent a serious threat to the health or safety of a particular person or to the public.
- **Security:** ASTRA Behavioral Health, LLC may give your data for military, national security, and prisoner care purposes.
- **Government eligibility:** ASTRA Behavioral Health, LLC will give your data to government entities involved with your health care benefit eligibility.
- **Marketing**: ASTRA Behavioral Health, LLC may use your data to contact you to give your information about relative benefits and services. However, ASTRA Behavioral Health, LLC CANNOT give your information to companies for advertising or solicitation without your permission.
- **Business Associates:** ASTRA Behavioral Health, LLC must share your data with other state, federal and commercial partners it contracts with to perform its normal business. We ask these groups to protect your data through formal agreements.
- **Health Oversight and Quality Assurance:** ASTRA Behavioral Health, LLC may use and give out your data to doctors and nurses to help improve your care. Staff, committees, and outside agencies that monitor Medicaid quality of care may also see your data.
- **Appointment Reminders:** ASTRA Behavioral Health, LLC may use your mental health information to remind you of appointments.
- **Mental Health Promotion and Disease Prevention:** ASTRA Behavioral Health, LLC may use your health information to tell you about disease prevention and mental health care.
- **Individuals Involved with Payment of Your Care:** ASTRA Behavioral Health, LLC may give out your health information to a friend or family member who is helping with your care of with payment for your care if necessary.
- **Lawsuits and Disputes:** ASTRA Behavioral Health, LLC must give your data under a court order.
- **Law Enforcement:** ASTRA Behavioral Health, LLC will give out your data to law enforcement only where allowed by federal or state law or require under a court order.

When ASTRA Behavioral Health, LLC May Not Use or Disclose Your Mental Health Information Without Authorization

Other than for the allowed reasons listed above, ASTRA Behavioral Health, LLC will not use or disclose your data without written permission (authorization) from you. If you do authorize us to use or disclose your data in other way, you may revoke your permission in writing at any time. Once you revoke your permission, ASTRA Behavioral Health, LLC will no longer be able to use or disclose your data for the reasons stated in your original authorization.

YOUR INDIVIDUAL PRIVACY RIGHTS UNDER HIPAA

Right to Request Confidential Communications
You have the right to ask ASTRA Behavioral Health, LLC to communicate with you at a certain alternative number or location other than your home of record. ASTRA Behavioral Health, LLC will do this only when necessary to protect your safety or health.

Right to Request Restrictions
You have the right to ask that your protected health data not be given out or used. This is called requesting a restriction. ASTRA Behavioral Health, LLC has the right to deny any requests for conducting its required business processes

Right to Withdraw Authorization for Usage and Disclosure
ASTRA Behavioral Health, LLC must have your written permission (authorization) to use or give out your information for reason other than the special exceptions described above. ASTRA Behavioral Health, LLC may ask you to give permission by singing a form called an authorization.

Right to Access
You have to the right to look at and get a copy of your personal information maintained by ASTRA Behavioral Health, LLC. This is called a designated record set. ASTRA Behavioral Health, LLC designated record set includes enrollment, claims data and payment records made in your behalf.

- ASTRA Behavioral Health, LLC will provide one (1) copy of records per 12-month period free of charge. You will be charged for additional copies.
- ASTRA Behavioral Health, LLC will respond to requests within 30 days of receipt. (Extra 30 days may be asked for if necessary, we will let you know if we need extra time).
- ASTRA Behavioral Health, LLC has the right to keep you from having or seeing all or parts of your records for specific reasons related to HIPAA and state law.
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Right to Amend
You have the right to ask that information in your records be changed if they are not correct. A response will be given within 60 days of receipt. **Please note:** If you wish to change your records, you must contact the provider who wrote the record to request a change. ASTRA Behavioral Health, LLC may deny the request for change if:

- The information was not written or is not kept by ASTRA Behavioral Health, LLC
- The information is information you are not allowed to see and copy.
- The information is already correct and complete.

Right to Paper Copy of Notice
You have the right to receive a paper copy of this notice at any time.

Changes to This Notice of Privacy Practices
ASTRA Behavioral Health, LLC has the right to change this privacy notice at any time. If we do make a change, we will revise this notice and promptly distribute it to all recipients. We are required by law to comply with the current version of this notice until a new version has been mailed out or received at the office.

Complaints
If you believe your privacy rights have been violated and wish to make a complaint, you may file a complaint by calling/emailing:

OMBUDSMAN
Robin Flowers
Phone: (270) 506-2730 x 138
Fax: (270) 900-0704
rflowers@astrabh.com

Secretary of Health and Human Services, Room 615F
200 Independence Ave. SW
Washington, D.C. 20201

For additional information, call 877-696-6775
United States Office to Civil Rights by calling 866-OCR-PRIV (866-627-7748) or 866-788-4989 TTY.

Policy of Non-Retaliation
ASTRA Behavioral Health, LLC cannot take away your mental care benefits or retaliate in any way if you choose to file a privacy complaint or exercise any of your privacy rights.