PATIENT CONTACT INFORMATION

PATIENT LEGAL NAME____ DOB___________SEX_____

ADDRESS____ CITY_______________________ STATE________ ZIP___________

PHONE NUMBER_______________________________________EMAIL____

PREFERRED PHARMACY____

EMERGENCY CONTACT INFORMATION

NAME_______________________________________ RELATION______________________ PHONE #______________________

INSURANCE INFORMATION

WHO IS THE SUBSCRIBER? PATIENT_____ OTHER_____ (IF OTHER PLEASE COMPLETE INFORMATION BELOW)

PRIMARY POLICY HOLDER____ DOB_____________________

RELATIONSHIP____ EMPLOYER_____________________________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby certify that the insurance coverage information I have reported is correct. I authorize Strength of Mind to apply for insurance benefits on my behalf for covered services rendered. I also authorize the release of any medical information necessary to process all insurance claims. I request the payment from my insurance company be made directly to Strength of Mind. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

PAYMENT CONSENT

I hereby authorize Strength of Mind to charge my credit/debit card for balances due for missed or canceled appointments without 24-hour notice, as well as services rendered that my insurance company quoted as my financial responsibility.

TELEPSYCHIATRY CONSENT

I hereby consent to engaging in telepsychiatry with Strength of Mind as part of my psychiatric evaluation and treatment. I understand that “telepsychiatry” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

By signing below, I state that I have read and understand all Strength of Mind’s office policy statements and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I will receive automated text and phone call reminders. I understand that I may withdraw from treatment at any time.

PATIENT NAME (PLEASE PRINT):____

SIGNATURE:____ DATE:_________________

(Patient, Parent, or Legal Guardian)

Broken Arrow, OK
8937 South Garnett Road, 74012
Phone: 918-872-9777 Fax: 918-872-9779

Claremore, OK
2990 North Sioux Road, 74017
Phone: 918-342-2622 Fax: 918-342-2641

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

PAITENT NAME____ DOB_______________________

Please check ONE below:

____ I **REFUSE** to give authorization for any release of information

____ I authorize Strength of Mind (SOM) to communicate regarding the above-named client with the following individual or agency. This authorization will allow SOM to share protected health information (PHI). This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Provider/Entity:____ Phone:___________________ Fax:___________________

Address:____ City:_______________________ State:_______ ZIP:___________

Other Name/Relation:____ Phone:_______________ Fax:________________

Address:____ City:_______________________ State:_______ ZIP:___________

Disclousure may include the following verbal or written information: (check all that apply)

____Demographics ____Psychological testing results

____Copy of complete medical record ____Medication records

____History & Physical ____ Summary of treatment records & contact dates

____ Psychosocial assessment ____All of the above

_____Other (specify)____

I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

Signature: ____ Date: ______________________________

(Patient, Parent, or Legal Guardian)

EXPIRATION: This authorization will expire on (date or event):____

If no date or event is specified, the authorization shall expire 30 days after the end of treatment.

TF 3/22

Client Information, Office Policy Statement, and Informed Consent

Welcome!
Thank you for choosing Strength of Mind for your outpatient behavioral health needs. Please take a moment to familiarize yourself with the following information. Please feel free to ask the office staff or your clinician any questions you may have regarding any of these policies. **In the event of an emergency, call 911 or go to the nearest emergency room.**

Goals/Aims and Statement of Patient Rights and Responsibilities:
The major goal for treatment is to help you identify and cope more effectgively with problems in daily living and to deal with inner conflicts which may disrupt your abillity to function effectively. This is accomplished by:

1. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
2. Identifying personal treatment goals.
3. Promoting wholeness through psychiatric treatment and/or psychological and spiritual healing and growth.

You are responsible for providing necessary information to facilitate effective treatment and are expected to play an active role in your treatment. This includes working with your clinician to outline your treatment goals and assess your progress. There may also be negative consequences if you do not follow trhough with recommended treatment(s).

As a patient receiving services through Strength of Mind, you have the following rights/ responsibilities:
To help plan your care and make changes to it. To expect that teaching materials and aids will be written or presented in a manner you can understand. To have your records kept confidential except when written consent has been given. To expect that services will be provided in a timely manner. To receive care without discrimination because of race, religion, age, sex, or ethnic origin. To refuse services or withdraw yourself from treatment at any time. To participate in planning your care and to be under supervision of Strength of Mind clinicians.

Financial Policy
Payment is due at the time of service. We will file your insurance claim on your behalf, but you are responsible for deductibles, co-insurance, co-payments, and any other costs not paid for by your insurance company. It is your responsibility to familiarize yourself with your insurance benefits and notify the practice of any changes in your insurance plan. All patients are required to have an active card on file. Cards on file will be charged for; missed or late canceled appointments, missed co-pays, deductible and co-insurance, any non-covered services and/or denial of services allocated to patient responsibility. Checks written and returned to us for non-sufficient funds will be assessed a $38 fee. This fee plus non-sufficient original amount of the check will be due to our office immediately and must be paid with a different form of payment.

Appointment Cancellation, No Show, and Late Arrival Policy and Reminders
Our policy requires patients to cancel 24 hours in advance of their appointment to avoid a cancellation fee. If their appointment is on a Monday or following a long weekend, the cancellation must be made on the previous business day. Patients are expected to arrive on time for their scheduled appointments. Patients who arrive more than 10 minutes late, may not be seen and will be charged a late cancellation fee. You will be billed:

- $75 for a missed or late cancelled initial appointment or follow up appointment with no show or no call
- $40 for each follow up appointment cancelled with less than 24-hour notice
- $150 for psychological/neuropsychological testing cancellations without 24-hour notice

Insurance companies do not reimburse patients for missed appointments; this will be your financial responsibility. **We reserve the right to cancel your appointment due to your tardiness or to terminate services for attendance related issues.**
Strength of Mind will attempt to confirm appointments via text two days prior to your scheduled appointment, however, it is your responsibility to know the date, time, and location of your appointment. Inability or failure to receive a reminder via text is not a reason for waiver of fees.

Letters, Paperwork, and Records
To request letters, paperwork, or records we require that you complete the "Authorization to release/obtain information" form in entirety. Incomplete forms will not be processed and will delay your request. All letters and paperwork that are approved by the Strength of Mind will be charged a fee. Each fee is determined based on the amount of work required by the staff and/or clinician. **Payment is due prior to any letters or paperwork being completed.** Processing can take up to 30 days.

Court Testimony and Custody Evaluations:
Strength of Mind therapists and physicians make every effort to maintain confidentiality and therefore do not testify in court regarding custody, divorce action, or other legal matters. You are not permitted to contact your therapist personally or via your attorney for such matters, nor are you permitted to request your clinician to testify in court on your behalf. If your therapist is contacted or subpoenaed for testimony, you agree to pay all court costs, legal fees, and hourly rates for your therapist's time. This may result in termination of services.

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, Strength of Mind originates and maintains medical and health records describing my health history, symptoms, examination and test results. Diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means for a third-party payer to verify that services were billed as actually provided
- And a tool for routing healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing. I understand and have been provided with a "Patient Privacy Notice" that provides a more complete description of information uses and disclosures. I understand that I have the right to review the "Patient Privacy Notice" prior to signing this consent. I understand that Strength of Mind, reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and the Strength of Mind is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon. By Oklahoma law we are required to notify you…**that the information authorized for release may include records which may indicate the presence of a communicable, noncommunicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

Treatment of a minor
Parents legally have rights to all information their children share in therapy. However, Strength of Mind makes it a practice to keep what is shared private unless it deals with unsafe or illegal behavior. Strength of Mind will not withhold information from either parent unless the proper legal documentation stating a parent's rights have been terminated is provided.

Patient Privacy Policy

Effective: 9/23/2021 TF

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.
If you have any questions about this notice, please contact our patient representative.

WHO WILL FOLLOW THIS NOTICE:
This notice describes our office's practices and that of:
Any health care professional authorized to enter information into your file or record.
All employee, staff, and other personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in our practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:
-Make sure that medical information that identifies you is kept private.
-Give you this notice of our legal duties and privacy practices with respect to protected medical information about you;
-Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION
The following categories describe different ways that we use and disclose protected medical information. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.
For treatment: We may use protected medical information about you to provide you with medical treatment or services. We may disclose protected medical information about you to doctors, nurses, technicians, medical students, pharmacists, or other personnel who are involved in taking care of you. Different departments of our practice also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, and x-rays. We also may disclose protected medical information about you to people outside of practice who may be involved in your medical care, such as family members or others we use to provide services that are part of your care.
For Payment: We may use and disclose protected medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about treatment you received so your health plan will pay us or reimburse you. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment. We also may use and disclose your information to obtain payment from third parties that may be responsible for such cost, such as family members. We may use your information to bill you directly for services and items.

Law Enforcement: We may release protected information if asked to do so by a law enforcement official:
-In response to a court order, subpoena, warrant, summons, or similar process
-To identify or locate a suspect, fugitive, material witness, or missing person
-About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
-About a death we believe may be a result of criminal conduct
-In emergency circumstances to report a crime, the location of the crime or victims, the identity, description, or location of the person who committed the crime.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU
You have the following rights regarding protected information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and receive medical information that may be used to make decisions about your care. This includes medical and billing records but does not include psychotherapy notes. Review of psychotherapy notes will be made at the discretion of Strength of Mind, to make sure that reviewing psychotherapy notes will not cause further harm to you.

To inspect and/or receive copies of your medical information you must submit your request to Strength of Mind Medical Records Department. If you request a copy of the information, we may charge a fee for the cost of copying, mailing, or other supplies associated with your request. By the statute in Oklahoma, we may charge you $1.00 for the first page and $0.50 per page for pages thereafter, plus our postage costs.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may amend the information. You have the right to request an amendment for as long as the information is kept by our practice.

To request an amendment, your request must be made in writing and submitted to Strength of Mind, Medical Records Department. In addition, you must provide a reason that supports your amendment request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend that information that:
-Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
-Is not part of the medical information kept by our practice
-Is not part of the information kept by our practice
-If our judgement is accurate and complete as it appears or as it was at the time it was originally captured or recorded
Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures.” This is a list of the disclosures we have made of your medical information.

To request this list of accounting of disclosures, you must submit your request in writing to Strength of Mind, Medical Records Department. Your request must state a period of time, which may not be longer than SIX years.

Right to Request Restrictions: You have the right to request a restriction or limitation on the protected medical information we use or disclose about you for treatment, payment or health care operation. However, we must receive your restriction in writing before we have made such disclosures. Also, if you restrict our right to use your protected medical information for treatment, payment, or health operation, we reserve the right to immediately withdraw our services from you and terminate the physician-patient relationship.

You also have the right to request a limit on the protected medical information we disclose about you to someone who is involved in your care, such as a family member or friend.

Appointment Reminders: We may use and disclose protected medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives: We may use and disclose protected medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose protected medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may release protected medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition. In addition, we may disclose protected medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

As Required by Law: We will disclose protected medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose protected medical information about you when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

SPECIAL SITUATION:

Military and Veterans: If you are a member of the armed forces, we may release protected medical information about you as required by military command authorities. We may also release protected medical information to a foreign military authority if you are in their service.

Workers Compensation: We may release protected medical information about you for workers compensation or similar programs. These programs provide benefits for work related injuries or illness. Release of such information is controlled by state and/or federal law.

Public health Risks: We may disclose protected medical information about you for public health activities. These activities generally include the following:

-To prevent or control disease, injury, or disability
-To report births and death
-To report a known or suspected crime
-To report child abuse or neglect
-To report vulnerable adult abuse
-To report reactions to medications or problems with products
-To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
-To notify the appropriate government authority if we believe a patient has been the victim of domestic violence. We will only make this disclosure if you agree or when required by law

Health Oversight Activities: We may disclose protected medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights law.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in a dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
To request restrictions, you must make your request in writing to Strength of Mind, Medical Records Department. In your request for restrictions, you must tell us 1. What information you want to limit, 2. Whether you want to limit or use, disclosure, or both, and 3. To whom you want the limits to apply, for example, you can request that we only contact you at work, or at home, or by mail, or by phone.
To request confidential communications, you must make your request in writing to Strength of Mind. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
Right to a Copy of this notice: You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for protected medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you are in our office for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, you may do so in writing to:
Attention: Patient Representative
8937 S. Garnett Road
Broken Arrow, Ok.
74012

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of protected medical information not covered by this notice or the laws that apply will be made only with your written permission. If you provide us permission to use or disclose protected medical information about you, you may revoke the permission in writing at any time. If you revoke your permission, we will no longer use or disclose protected medical information about you for the reasons covered by your written authorization. You

understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.