Notes and Instructions on completing this form

Note: Mr. Olgehart is unable to prescribe controlled medications at Mason Family Counseling.

The following medications include:

Hypnotics	Stimulants	Benzodiazepines
Ambien (zolpidem)	Adderall	Alprazolam (Xanax)
Belsomra (suvorexant)	Concerta	Chlordiazepoxide (Librax)
Butisol (butabarbital)	Daytrana	Clobazam (Onfi)
Doral (quazepam)	Dexedrine	Clonazepam (Klonopin)
Edluar (zolpidem)	Spansule	Clorazepate (Tranxene T-Tab)
Estazolam	Focalin	Diazepam (Valium)
Flurazepam	Focalin XR	Estazolam (ProSom)
Halcion (triazolam)	Metadate CD	Flurazepam (Dalmane)
Hetlioz (tasimelteon)	Metadate ER	Lorazepam (Ativan)
Intermezzo (zolpidem)	Methylin ER	Midazolam (Versed)
Lunesta (eszopiclone)	Ritalin	Oxazepam (Serax)
Restoril (temazepam)	Ritalin LA	Temazepam (Restoril)
Seconal (secobarbital)	Ritalin SR	Triazolam (Halcion)
Sonata (zaleplon)	Vyvanse	
Zolpimist (zolpidem)		

If you require any of these medications please call or email our office and cancel your appointment.

This form can be completed using Adobe Acrobat or by printing out this form and complete it by hand.

Once completed the form can be returned via email or printed and scanned and returned by email.

The form may also be submitted via fax at 513-229-0202

Mason Family Counseling

JOSHUA OGLEHART, MSN, CRNP, PMHNP-BC, PMHS, CARN-AP

CLIENT DEMOGRAPHIC FORM **Date**

Last Name First Name Age

Mailing Address

City State Zip

Cell Phone Home Phone

Email

Client Date of Birth Client's SSN

Marital Status Gender Gender Identity

IN ORDER TO FOLLOW UP WITH YOU DURING AND AFTER SERVICES, CHECK EACH APPLICABLE BOX

Permission to use mailing address?

Permission to Call Cell? Permission to Leave Message on Cell?

Permission to Call Home? Permission to Leave Message on Home?

Special Instructions

How would you like to pay for your appointments?

◯ **Self Pay** ◯ **Insurance**

Insurance Company Co Pay

Insurance ID Number Insurance Group Number

Insurance Mailing Address State Zip

Insurance Company Phone Does your Insurance Require Pre-Authorization?

Benefit Holder	**Guarantor Information**
Name of Benefit Holder	Name of Guarantor
Date of Birth	Guarantor DOB
Benefit Holder SS#	Guarantor Address
Benefits Holders Relationship to Client	City, State Zip:

Who Referred you?

JOSHUA OGLEHART, **MSN, CRNP, PMHNP-BC, PMHS, CARN-AP**

Mason Family Counseling

Permission to Treat/Fee Agreement

This ia a consent to treat/fee agreement dated below with Joshua Oglehart MSN, CRNP, PMHNP-BC, PMHS, CARN-AP.

1. Name: _____ is of the opinion that the Joshua Oglehart has the necessary qualifications, experience and abilities to provide services and I hereby give permission to treat.
2. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that services are rendered. It is your responsibility to know any stipulations of your insurance such as co-pay amount, need for referral forms, deductibles, and need for treatment pre-authorization. For example, your insurance company may require that you have your sessions authorized prior to being seen for the first time. You will need to check for and obtain initial authorizations otherwise you will be responsible for the payment. In addition, you will need to keep track of the number of sessions allowed; if this amount is exceeded you will be responsible for the payment.
3. Please bring all paperwork including insurance authorizations to my attention at the beginning of your session. I prefer that all such work be done in your session so that you are fully aware of and can participate in what is written. If you give me the paperwork at the end of a session, I may not be able to complete it during the session, and I charge for paperwork that is done outside of sessions.
4. Please inform me immediately of any change in insurance coverage, employment, address, and phone numbers. Changes in insurance coverage could result in your sessions not being reimbursed by your insurance company, and then you would be responsible for the charges.
5. Co-payments, in the form of cash or check, are due at the beginning of each session. There is a $25 charge for a returned check.
6. If you are paying out of pocket, an initial session (lasting 1 hour) will cost $200.00 and each follow-up session will cost $100.00.
7. Other expenses:
    7.1. For unpaid charges over 30 days old (from the date of the first billing), a service fee of 2% of the balance per month will be applied. A past due account may cause interruption of service.
    7.2. $25 for paperwork completed outside of a session
    7.3. $85 for a written report for any purpose (this fee must be paid before the report is released to you)
    7.4. $25 per 15 minutes for a phone call lasting longer than 5 minutes
8. **For telehealth (phone or video) appointments you must be in the state of Ohio**

I have read the above information. I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered.

_____

Patient Date

_____

Provider Date

Joshua Oglehart and Mason Family Counseling
Late Cancellation / No-Show Policy and Credit Card Authorization Form

Joshua Oglehart and Mason Family Counseling is privileged to provide Medication Evaluation and Management for the patients. We work diligently to maintain a high level of professional and personalized service, and we strive to accommodate our patient's needs in a timely manner. These objectives require careful planning and coordination among many individuals in our office.

We understand that things happen and sometimes a patient cannot appear for their scheduled appointment. If you need to cancel or reschedule an appointment, please call our office at (513) 229-7900 (no e-mails) at least 48 hours in advance of your scheduled appointment. For Monday appointments, cancellations must be made by noon on the preceding Friday.

Our providers set aside valuable time just for you and we often maintain a wait list, which helps us see everyone who requires our services. When a patient cancels an appointment without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of other patients. Therefore, in the event of a late cancellation (less than 48 hours) or no-show, we will charge your credit card one hundred dollars ($100.00) for missed initial appointments and fifty dollars ($50.00) for missed follow up appointment. Please be aware that all fees charged by Mason Family Counseling pursuant to this policy are reflective of a missed business opportunity and are not reimbursable by your insurance provider. Thank you for your understanding.

Please note: Mason Family Counseling's receipt of this form is required to reserve your upcoming appointment. If we have not received a completed, signed copy within three (3) business days from the date you called to schedule, the appointment will be canceled, and we will not be able to reschedule until your form is received.

_____ (Type Initials) I understand that when making their appointment, no controlled medications will be prescribed. We do not provide stimulant therapy which includes medications such as Xanax, Klonopin, Ativan and others as known as benzodiazepines; Adderall, Vyvanse, Ritalin and others known as stimulants. Hypnotics that include Lunesta, Ambien or their derivatives.

CARDHOLDER INFORMATION

Name: _____

City: _____ State: _____ Postal Code: _____

Telephone: _____

_____ (Type Initials) I authorize a late-cancellation charge against my credit card for one hundred dollars ($100.00) if I cancel an initial appointment or fifty dollars ($50.00) if I cancel a follow up appointment with less than 48-hour notice or by noon on the preceding Friday for Monday appointments.

_____ (Type Initials) I authorize a no-show charge against my credit card for one hundred dollars ($100.00) if I do not appear for my initial scheduled appointment or fifty dollars ($50.00) if I do not appear for my follow up scheduled appointment.

CREDIT CARD INFORMATION

Credit Card Type: ◯ Mastercard ◯ Visa ◯ American Express ◯ Discover

Card Number: _____

Expiration Month/Year: _____ Security Code: _____

Cardholder Signature: _____ Date: _____

JOSHUA OGLEHART, MSN, CRNP, PMHNP-BC, PMHS, CARN-AP

Mason Family Counseling

General Information

1. I DO NOT provide 24-hour emergency call service for after hours or weekends. Emergencies are to be handled at your local emergency room in the event of symptom deterioration or when experiencing severe/intolerable side effects. You are responsible for monitoring your medications and when you need refills; refill requests will be answered during clinic hours Monday and Tuesday from 10AM to 7PM emailing me directly at: joshua@masonfamilycounseling.com

2. Initial sessions are 1 hour, and follow-up appointments last 20 to 30 minutes.

3. I will keep all information that you provide me confidential, and this obligation of mine will last indefinitely. The only times that I will reveal confidential information are if you sign a release of information, if you are in an emergency situation (for example your being admitted to a hospital), if I am required by law, and if your insurance company requires it for reimbursement. You may choose not to authorize the release of information to your insurance company; however, this may prevent you from using your insurance benefits. Your signature below indicates your willingness to disclose the needed information to your insurance company so that you may use your benefits.

4. Medication refill policy:
   - A) You are expected to attend all scheduled follow-up appointments which will minimize any need for refills between appointments (I will provide for enough medication to last you between scheduled appointments.)
   - B) However, if you need a medication refill, email me directly at joshua@masonfamilycounseling.com with the following in your message: **Your name, your birth date, name of medication, dosage, and pharmacy phone number. I will call in enough medication to last until your next appointment.** I will call the pharmacy during my clinic hours.
   - C) Only under extenuating circumstances will I refill a prescription early (before you should be out of the medication.)

5. In addition to prescribing medication, I will provide you with information about your diagnosis, prognosis, and treatment including your medication.

_____

Patient Date

_____

Provider Date

Behavioral Health/Primary Physician Patient Care Communication Form

Patient Name _____ Date of Birth _____

Behavioral Health Provider:
Name: Joshua Oglehart, APRN
Mason Family Counseling
Address: 5134 Cedar Village DR.
Mason, Ohio 45040
Phone: 513-229-7900
Fax: 513-229-0202

Primary Physician:
Name: _____
Address: _____
Phone: _____
Fax: _____

Does Patient have a primary physician? _____

Authorization to Disclose Information

I understand that records or information about my mental health including alcohol and drug abuse are confidential; they are protected by applicable state and federal laws, and cannot be disclosed without my written consent unless otherwise provided for in state and federal regulations. I also understand that any information about me concerning AIDS, HIV infection, and AIDS related conditions and any tests, counseling, and the treatment thereof cannot be released without my authorization. I understand that I may revoke this consent at any time.

_____ (Type Initials) I authorize any information on my care to be shared between providers listed above to facilitate my treatment. This authorization will continue during my entire course of treatment by Mason Family Counseling/Joshua J. Oglehart and may include information concerning psychiatric diagnosis and treatment; alcohol and drug use; and/or HIV testing, diagnosis or treatment of AIDS, and AIDS related conditions.

_____ (Type Initials) I do not wish to have information on my care to be shared between my physicians, names above, for the purpose of facilitating my treatment.

_____

Patient Signature Date

To be Completed by Behavioral Health Provider:

Presenting Problem: _____

Diagnosis: _____

Treatment Plan (including medications prescribed): _____

Information Requested from Primary Physician: _____

To be Completed by Primary Physician:

Please provide the information requested as well as any other information relevant to this patient's treatment (attach pages or forms from the patient's chart as needed): _____

Client Symptom Self Evaluation

Completed by Client

*Information Remains **Strictly** Confidential*

Name _____ **Date** _____

WHAT CONCERNS DO YOU CONTINUE TO HAVE ABOUT HOW YOU ARE FEELING?

Symptoms (please mark all that apply):

Emotional:		**Physical:**
☐ Feeling of extreme happiness	☐ Lack of enjoyment of ususal activites	☐ Lack of energy
☐ Feeling of extreme sadness	☐ Increased use of alcohol/drugs	☐ Dry mouth
☐ Feeling stressed	☐ Avoiding things	☐ Memory problems
☐ Feeling nervous or anxious	☐ Trouble performing your job	☐ Chronic weakness
☐ Feeling fearful	☐ Poor interpersonal skills	☐ Chronic pain
☐ Feeling worried	☐ Reckless behavior	☐ Muscle tension/aches
☐ Indecisiveness	☐ Trouble concentrating	☐ Numbness
☐ Depression	☐ Not getting along with friends/family	☐ Sweating/Clammy hands
☐ Easily irratated	☐ Hearing voices	☐ Nerve problems
☐ Parnoid thoughts	☐ Fear of situations where escape is difficult	☐ Trembling/twitching
☐ Self-esteem problem	☐ Obsessions or compulsions	☐ Hot flashes
☐ Feeling guilty	☐ Thoughts of hurting yourself	☐ Dizziness
☐ Sudden feeling of panic	☐ Thoughts of hurting others	☐ Frequent urination
☐ Perfectionism	☐ Thoughts of killing yourself	☐ Stomach or bowel problem
☐ Change of sleeping habits	☐ Thoughts of killing others	☐ Weight changes
☐ Procrastination	☐ Suicide attempts	☐ Change in eating habbits
☐ Crying spells	☐ Acting violently	☐ Self-starvation
☐ Problems with anger	☐ Intrusive thoughts	☐ Chest pains
☐ Exaggerated startle response		☐ Shortness of breath
		☐ Heart symptoms
		☐ Trouble swallowing
		☐ Change in sexual interest

HOW LONG HAVE YOU HAD THE SYMPTOMS CHECKED ABOVE? ***(APPROXIMATE DATE SYMPTOMS BEGAN)***

ANY DETERIORATION IN JOB / SCHOOL PERFORMANCE DUE TO THE PROBLEM?

☐ Attendance	☐ Absences Monday/Friday's	☐ Tardiness
☐ Decrease in Productivifity	☐ Erratic Behavior	☐ Conflict with supervisors
☐ Discipline	☐ Conflicts with fellow employees	☐ None

CONSEQUENCES OF DETERIORATING PERFORMANCE ON WORK OR SCHOOL:

On a Scale of 1-5, how would your rate your distress? (l is low, 5 is severe distress) _____

Medical Condition You Have: (If yes check)

☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease
☐ Blood Problems	☐ Bone/Joint Problems	☐ Brain Problems
☐ Skin/Hair/Nail Problems	☐ Liver Disease	☐ Respiratory Problems (Breathing
☐ Genital	☐ Kidney/Bladder	☐ Cancer
☐ Allergies	☐ Eyes	☐ Autoimmune
☐ Chronic Pain	☐ Gastrointestinal	☐ Head Injury

Other health problems not listed above:

Sleep Problems:

Appetite Problems:

Past Health Problems (include difficulties with developmental milestones under age 18)

Medication currently using: If NONE, type your initials here

Medication	Dosage	Time Taken	Prescribing Doctor	Reason Prescribing

Medication Allergies: If **NONE**, type initials here

If yes what:

PAST TREATMENT INTERVENTIONS:

Date	**Medical & Surgical**	**Provider/Program/Hospital**
Date	**Psychiatric**	**Provider/Program/Hospital**
Date	**Chemical Dependency**	**Provider/Program/Hospital**

Medical Conditions that Run in Your Family: (If yes check)

☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease
☐ Blood Problems	☐ Bone/Joint Problems	☐ Brain Problems
☐ Skin/Hair/Nail Problems	☐ Liver Disease	☐ Respiratory Problems (Breathing
☐ Genital	☐ Kidney/Bladder	☐ Cancer
☐ Alleriges	☐ Eyes	☐ Autoimmune
☐ Chronic pian	☐ Gastrointestinal	

Medical Conditions that Run in Your Family: (If yes check)

HEALTH HABITS INFORMATION:
For the following questions please base your answers on **the past month** (approximately).

- ☐ Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit?
- ☐ Have you been dieting to lose weight?
- ☐ Have you been dieting to lose weight?
- ☐ Have you experienced any increased feelings of sadness or hopelessness?
- ☐ Have you felt more anxious or worried than usual?

How often in the past month did you drink alcohol?:

For the **past month**, please fill in a number for each day of the week indicating the **typical number of alcohol drinks** you usually consume on that day.

Day of Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Number of drinks:							

- ☐ In the past year have you used any illicit or non-prescription drugs?
- ☐ During the past month have you participated in leisure/social/spiritual activities?

Have you ever had a DUI?

Yes: Details:

- ☐ In the past year, have you ever drunk or used drugs more than you meant to?
- ☐ In the past year have you spent more time drinking or using than you intended to?
- ☐ Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?
- ☐ Has anyone objected to your drinking or drug use?
- ☐ Have you ever found yourself preoccupied with wanting to use alcohol or drugs?
- ☐ Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?

FAMILY RELATIONSHIPS (Members of the family you are/were close to)

Name	Relationship	Age (or Year of Death)	Quality of Relationship: Excellent, Good, Fair, Bad	Lives with you:

RELATIONSHIP HISTORY: (List all marriages & divorces and/or lived together relationships)

Partner's First Name	Relationship Type	Length of Relationship	Reason Relationship Ended

WORK HISTORY: (Start with most recent)

Place	Position	From	To	Reason ended

PERSONAL & FAMILY HISTORY:		
Were you or any family member physically abused?	◯ **Yes** ◯ **No**	If Yes:
Were you or any family member sexually abused?	◯ **Yes** ◯ **No**	If Yes:
Were you or any family member emotionally abused?	◯ **Yes** ◯ **No**	If Yes:
Have you or any family member had a problem with drugs or alcohol?	◯ **Yes** ◯ **No**	If Yes:
Have you or any family member ever tried to commit suicide?	◯ **Yes** ◯ **No**	If Yes:
Is there any history of anxiety, depression or mental illness in your family?	◯ **Yes** ◯ **No**	If Yes:

Additional Comments:

Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. **Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclosed PHI to any other consultant only with your authorization, such as your primary care physician.**

For Payment. **We may use and disclosed PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility of coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.**

For Health Care Operations. **We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training and teaching purposes PHI will be disclosed only with your authorization.**

Required by Law. **Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.**

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

1. Required or allowed by law, such as, included, but are not necessarily limited to: the reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department), or abuse involving the elderly or the developmentally disabled/mentally retarded.
2. Required by Court Order
3. Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat, or to other persons as permitted by law, including you.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked, unless we have already relied on it.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Laura Vail Sage, LISW – 5134 Cedar Village Drive, Mason, OH 45040.

3. **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. We may charge a reasonable, cost-based fee for copies.
4. **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although e are not required to agree to the amendment.
5. **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
6. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
7. **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
8. **Right to a Copy of this Notice.** You have a right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Laura Vail Sage, LISW, at 5134 Cedar Village Drive, Mason, OH 45040 or with Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601. Voice Phone (312)886-2359; Fax (312) 886-1807; TDD (312) 353-5693.

We will not retaliate against you for filing a complaint.

The effective date of this notice is November 20, 2005.

Mason Family Counseling
5134 Cedar Village Drive
Mason, OH 45040
Phone (513)229-7900
Fax (513)229-0202

NOTICE OF PRIVACY PRACTICES

Mason Family Counseling

I, _____ (Print your name)
hereby acknowledge that I have received the Notice of Privacy Practices from Mason Family Counseling.

_____ _____
Signature of Client or Client's Guardian Date

If client and/or guardian refuse to sign, please note this here:

_____ _____
Providers Signature ***Date***

Informed Consent for Distance Treatment

I hereby consent to engaging in telemedicine with Joshua Oglehart and Laura Vail Sage, Inc as part of my treatment. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to a health care practitioner located in Ohio or outside of Ohio.

I understand that I have the following rights with respect to telemedicine:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

1. I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my Psychiatric Nurse, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine-based services have certain benefits and limitations. Care may not be as complete as face-to-face service if using chat or email. I also understand that if my Psychiatric Nurse believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a Psychiatric Nurse who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of treatment, and that despite my efforts and the efforts of my Psychiatric Nurse, my condition may not be improve, and in some cases may even get worse.

1. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
2. I understand that I have a right to access my medical information and copies of medical records in accordance with Ohio law. However, Laura Vail Sage, Inc is the legal owner of all written or recorded information.

If I have a life-threatening clinical emergency, I will dial 911 immediately or go to my nearest emergency room. If my crisis is not life threatening and my Psychiatric Nurse is unavailable, I will contact: http://www.befrienders.org/ or the National Suicide Hotline at 800-784-2433 for assistance.

If for some reason there is a technology problem and our session does not start on-time or is interrupted I will use an alternative contact given to me by my Psychiatric Nurse.

I understand that the time I have scheduled with my Psychiatric Nurse is reserved only for me and in compensation for the exclusive reservation of the Psychiatric Nurse's professional time; I will pay in advance for our session and will not obtain a refund if I fail to be available at the appointed time without 24 hours prior notice.

If I would like more information on my Psychiatric Nurses license, ethics or of the rules and regulations governing the above licenses, I can find information at:

- https://elicense.ohio.gov/oh_verifylicense/

My signature below indicates that I have read and understood the information provided above.

Name: _____ Date: _____

Consent to Treat Minor

Joshua Oglehart and Mason Family Counseling

Only required for Minors

I, _____ custodial parent/legal guardian of

_____, age _____,

authorize Joshua J. Oglehart to assess and treat my child in this outpatient counseling setting.

I agree to take part in the counseling process as needed, and understand the format of counseling may include any combination of the following: Individual sessions, with minor child, family sessions, and sessions with the parental unit.

Parent #1/Guardian's

Signature _____ Date _____

Relationship _____

Parent #2/Guardian's

Signature _____ Date _____

Relationship _____

(I like to get both parents signatures when it is possible).

Signature of Provider _____ Date _____

Children under 18 years of age under Ohio law generally have no right to confidentiality where their parent(s)/legal guardian(s) are involved, with the exception, that minors 14 years of age or older may receive certain limited outpatient services without the information being disclosed to the parent(s) or guardian(s) under most circumstances. Other than that specific exception, both parent(s)/legal guardian(s) generally have a right to obtain all information on their minor children, unless specifically blocked from access by a court order.

***Signature of Minor Child/Acknowledging he or she has read the above statement:

_____ Date _____

“Good Faith Estimate” Joshua Oglehart, APRN

This form is required only for “Self-Pay” clients i.e., clients not using insurance.

Under the law, health care providers need to give patients who don’t have insurance or who are not using insurance an estimate of the bill for medical items and services.

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a “Good Faith Estimate” of expected charges.

Mason Family Counseling
5134 Cedar Village Dr. Mason, OH 45040
Contact Person: Laura Sage
Phone: 513-229-7900
Email: Office@MasonFamilyCounseling.com
National Provider Identifier: 1699758250
Taxpayer Identification Number: 043604776

Details of Services

Service	Diagnosis Code	Service Code	Quantity (Appointments) **	Expected Cost	Total Expected Cost *
Initial Session	TBD	99205	1	$200.00	$200.00
Medication Management Appointment	TBD	99215	4 – 5 per Year	$100.00	$600.00 - $700.00

*Total expected cost is the cost of the initial appointment and follow up appointments combined.
**Cost is the same whether delivered in person or via telehealth.

Additional Health Care Provider/Facility Notes:

- Diagnosis Code will be determined after the initial appointment.
- The number of appointments are not known at this time. The number of appointments for this Good Faith Estimate is 4 to 5 per year as that is the “average” number of appointments our clients utilize for treatment. The number of appointments will be determined by the client and Mr Olgehart and whether they decide to continue with additional treatment.
- The cost for medication is not included in the Good Faith Estimate as Mason Family Counseling does not provide medication.

Disclaimers:

- There may be additional services your provider may recommend as part of the course of care and are not reflected in the good faith estimate.
- The information in this good faith estimate is only an estimate and that actual services or charges may differ from the good faith estimate.
- You have the right to initiate a patient-provider dispute resolution process if the actual billed charges substantially exceed the expected charges included in the good faith estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises. Your dispute will not adversely affect the quality of health care services furnished to you.
- This good faith estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

Type or sign your name in the box below to acknowledge receipt of this Good Faith Estimate:

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises

AUTHORIZATION FOR RELEASE OF RECORDS OR INFORMATION
As required

I, _____ _____
(Print name of patient/client) (Social Security Number)

hereby give permission to Mason Family Counseling
Laura Vail Sage LLC
5134 Cedar Village Dr
Mason, OH 45040

◉ Disclose Information to OR ○ Obtain Information from

_____

(Name of agency, attorney, school counselor, therapist, etc.)

Mailing Address _____

City _____ State _____ Zip _____

INFORMATION TO BE DISCLOSED/OBTAINED:		
☐ **My entire mental health record** AND/OR ☐ **My entire substance abuse record**		
OR by the mark below I authorize release of *Only* the following information:		
☐ Substance Abuse Evaluation	☐ Diagnois/Assesment	☐ HIV/AIDS - Related Treatment
☐ Treatment Recommendations	☐ Treatment Plan	☐ Sexually Transmitted Diseases
☐ Expected Length of Treatment	☐ Attendance Record	☐ Progress Report on my Treatment
☐ Psychiatric Nurse Notes Only (By checking this item I am waiving any Psychiatic Nurse patient privilege)		
☐ Other If "Other" specify: _____		

FORM IN WHICH INFORMATION SHOULD BE RELEASED:			
☐ Verbal	☐ Photocopied	☐ Written	☐ Faxed
☐ Other If "Other" specify: _____			

THE PURPOSE FOR SUCH DISCLOSURE IS:
☐ To permit continuity of care
☐ To permit case managment (Including reimbeursement determination) and proscessing of bebfit claims
☐ To enable my employer to make a determination on my employment status (including disability leave)
☐ Other (Specify): _____

I may revoke this consent in writing at any time except to the extent that action has been taken in reliance upon it. If 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 I do not revoke it, this consent will expire one (1) year after I have terminated treatment with this provider.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFRPart2, may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy Rule (45 CFR Part 164 and the Privacy Act of 1974 (5 USC 552a).

_____ _____
Signature of patient/client **Signature of parent, guardian, conservator, or authorized representative (when required)**

_____ _____
Date **Witness**