CLIENT INTAKE PACKET

WELCOME TO OUR AGENCY

CHAMPIONED MINDS
BEHAVIORAL HEALTH

TABLE OF CONTENTS

You will electronically complete the intake packet; there's no need to print this document for manual completion. This resource serves as a convenient reference for your convenience.

CHAMPIONED MINDS
BEHAVIORAL HEALTH

CLIENT DEMOGRAPHIC INFORMATION CONFIRMATION

Parent Name: _____

Client's Name: _____

Client's Date of Birth: _____

Client's Address: _____

City/State/ZIP: _____

Phone Number: _____

Email Address: _____

_____ _____

Signature of Client/Guardian Date

_____ _____

Signature of Intake Specialist Date

CHAMPIONED MINDS
BEHAVIORAL HEALTH

CLIENT HANDBOOK ACKNOWLEDGMENT

I acknowledge that I have received a copy of the Client Handbook from Championed Minds. **I further attest that during the client onboarding process, the Intake Specialist reviewed key policies and information contained in the handbook with me.** I understand and confirm that I have been provided with information on the following sections of the handbook:

I. Agency Introduction

Foundations of Our Treatment Philosophy
Comprehensive Assessment and Care
Clearly Defined Treatment Goals
Client-Centered Planning and Communication
The Role of the Therapeutic Relationship
Equitable Access and Minimal Intrusion
Client and Community Feedback
About Championed Minds

II. Client Policies & Procedures

Client Rights Policy
Client Grievance Policy
HIPAA Compliance Statement
Confidentiality of alcohol and other drug client records
(42 CFR Part 2)
Notice of Ethical Practices
Notice of Privacy Practices
Your Health Information Rights & Records Request
Financial Obligations & Fees

CHAMPIONED MINDS
BEHAVIORAL HEALTH

CLIENT HANDBOOK ACKNOWLEDGMENT CONT...

III. Program Information
Location & Hours of Operations
After Hours Information
Missed Appointments
Outpatient Services
Integrated Care Plan
Discharge and Transition Planning
Roles, Responsibilities, & Expectations

IV. Health and Safety
Important and Emergency Numbers
Client Safety
Disease Control and Prevention Resources:
Tuberculosis, Hepatitis B, Hepatitis C, and HIV/AIDS
General Information

I acknowledge that I have had the opportunity to ask questions and seek clarification on any policies or information provided to me. I understand that it is my responsibility to adhere to the policies and guidelines outlined in the handbook throughout my engagement with Championed Minds.

_____
Name of Child

_____
Name of Parent/Guardian

_____ _____
Signature of Client/ Parent Guardian Date

CHAMPIONED MINDS
BEHAVIORAL HEALTH

CLIENT CONSENT FOR TREATMENT

I understand and voluntarily consent for my child to receive treatment at Championed Minds. I also consent to the release of information for therapeutic, billing, supervision, and other related purposes during my treatment process. I acknowledge that this consent extends to therapists, staff, and service contractors affiliated with Championed Minds, as well as to other medical providers that may contribute to or assist in my care or the care of my child. For a comprehensive understanding of how my health information (or that of my child) might be utilized or disclosed under specific circumstances, I am aware that I can review the Notice of Privacy Practices available to me upon request from Championed Minds.

I acknowledge the obligation to provide payment at the time of each service. Should I file charges with my insurance carrier, I recognize my responsibility for all co-pays, deductibles, and any other charges that the insurance might not cover. I am fully responsible for understanding the specifics and details of my insurance plan. Furthermore, I understand that Championed Minds holds no binding agreement with either my insurance provider or me that ensures or guarantees reimbursement for the expenses incurred during my treatment sessions.

Should I need it, I am aware that I can request a receipt of payment, which can then be submitted to my insurance company. This submission will be for potential reimbursement based on the out-of-network benefits of my policy. I comprehend that all therapeutic services rendered to me or my child by Championed Minds are confidential, as permissible by both state and federal regulations. Licensed therapists are obligated by law to report any known or suspected cases of abuse – be it involving minors, the elderly, or disabled individuals. Furthermore, reporting is necessary if a client poses a danger to themselves or others, and in particular court-ordered situations. I can find a detailed outline of these confidentiality limitations in the Notice of Privacy Practices, available to me upon request.

Right to Withdraw Treatment: I am aware of my unequivocal right to rescind consent for treatment either for myself or my minor child at any given point in time. Should I decide to retract my consent, the professional team at Championed Minds will elucidate any implications or potential repercussions arising from halting the treatment. They will also assist in proposing alternative therapeutic strategies, ensuring continuity in care.

CHAMPIONED MINDS
BEHAVIORAL HEALTH

CLIENT CONSENT FOR TREATMENT CONT...

Right to Withdraw Treatment: I am aware of my unequivocal right to rescind consent for treatment either for myself or my minor child at any given point in time. Should I decide to retract my consent, the professional team at Championed Minds will elucidate any implications or potential repercussions arising from halting the treatment. They will also assist in proposing alternative therapeutic strategies, ensuring continuity in care.

_____

Name of Child

_____

Name of Parent/Guardian

_____ _____

Signature of Client/ Parent Guardian Date

CHAMPIONED MINDS
BEHAVIORAL HEALTH

GROUP CONFIDENTIALITY AGREEMENT

As part of your child's participation in group therapy sessions at Championed Minds, it is essential to understand and agree to the following confidentiality statement:

- **Mutual Respect for Privacy:** All group members are bound by a mutual agreement to respect the privacy and confidentiality of others. What is shared in the group stays in the group. This is crucial for creating a safe and trusting environment where all participants can speak freely and benefit from the therapy.
- **Confidentiality Commitment:** You and your child agree not to disclose any information about other group members outside of the session. This includes, but is not limited to, names, personal stories, experiences, and any sensitive information shared within the group setting.
- **Limits of Confidentiality:** While confidentiality is paramount, there are legal and ethical limits to confidentiality that you should be aware of. These include instances where there is a risk of harm to oneself or others, suspected child or elder abuse, or when legal requirements demand that confidential information be disclosed.
- **Facilitator's Role:** The group facilitator will maintain confidentiality to the fullest extent permitted by law. However, the facilitator may discuss the group themes or general progress without revealing personal identities, for supervision or consultation purposes, to enhance the group therapy process.
- **Shared Responsibility:** Confidentiality in a group setting is a shared responsibility. While the facilitator can guide the process and set the tone for confidentiality, it is the duty of each group member to uphold this agreement.
- **Understanding and Agreement:** By signing this consent for treatment, you acknowledge that you understand the importance of confidentiality in a group therapy context. You commit to upholding the confidentiality of the fellow group members and agree to the terms outlined in this Group Confidentiality Agreement.
- **Consent:** I have read and understood the Group Confidentiality Agreement and agree to abide by its terms as a participant in the group therapy sessions

_____

Name of Child

_____

Name of Parent/Guardian

_____ _____

Signature of Client/ Parent Guardian Date

CHAMPIONED MINDS
BEHAVIORAL HEALTH

CONSENT TO PHONE OR TEXT USAGE FOR GENERAL HEALTHCARE COMMUNICATIONS

Championed Minds may reach out to individuals using phone calls or text messages for various reasons, such as appointment reminders, collecting feedback about our services, or sharing general updates and information.

By agreeing to this, I permit the Championed Minds to contact me via phone calls or text messages on my cellphone or any number associated with it for the purposes mentioned above. This consent will be valid for all future communications unless I provide a written request for modification.

Please note: While Championed Minds doesn't impose any fees for this service, regular phone call and text messaging rates might apply based on your service provider.

_____ **I prefer not to receive reminder calls**

_____

Name of Child

_____

Name of Parent/Guardian

_____ _____

Signature of Client/ Parent Guardian Date

CHAMPIONED MINDS
BEHAVIORAL HEALTH

TELEHEALTH TREATMENT CONSENT

I hereby understand and voluntarily give consent for my child to partake in Telehealth services with Championed Minds. Telehealth encompasses real-time interactions via audio and video communication tools, allowing the client and the healthcare provider to connect from different locations. I recognize that Telehealth's secure video conferencing might be an occasional solution when attending in-person sessions becomes challenging or as a routine appointment method.

Understanding & Acknowledgments:

1. **Awareness of Benefits and Risks:** I am entitled to comprehensive information about the potential benefits and risks linked to Telehealth, alternate intervention methods, and the option of not pursuing treatment
    a. Benefits: Telehealth can lead to: Enhanced accessibility to mental health services, reduction in waiting periods and travel distances, better coordination with mental health experts and the possibility to consult with remote specialists.
        i. Opting out of Telehealth doesn't come with inherent benefits
    b. Risks: Engaging in Telehealth might involve: Infrequent technological malfunctions, potentially impacting communication quality. Possible delays in diagnosis or management due to equipment issues. An exceedingly rare chance that security measures might falter, risking personal health data privacy
        i. Refusing Telehealth might lead to deteriorating mental health symptoms
2. **Telecommunication Software Orientation:** I am assured of a proper introduction to the secure video software used for Telehealth
3. **Legal Protections:** I am informed that Telehealth is covered under federal and state laws that safeguard medical information privacy. Thus, I commit to authenticating the identity of both the client and myself during each session
4. **Consent Management:** At any given time, I reserve the right to give, deny, or revoke my consent for Telehealth services. I expect a thorough explanation regarding the implications of any such decision.
5. **Service Termination:** Should services be discontinued, I anticipate being informed in advance and actively involved in the transition planning process when feasible
6. **Regulatory Adherence:** I am aware that Championed Minds is obliged to meet all Telehealth standards stipulated by the Ohio Department of Mental Health and Addiction Services and relevant licensing bodies, inclusive of inter-state service provisions

CHAMPIONED MINDS
BEHAVIORAL HEALTH

TELEHEALTH TREATMENT CONSENT CONT...

Name of Child

Name of Parent/Guardian

Signature of Client/ Parent Guardian

Date

CHAMPIONED MINDS
BEHAVIORAL HEALTH

TELEHEALTH EXPECTATIONS

You and your child will be engaging in services through Telehealth, meaning your interactions with your provider will be facilitated online using electronic devices. To ensure the efficacy and integrity of these services, it's essential to approach Telehealth sessions with the same level of commitment and preparation as in-person appointments. The following guidelines will help ensure a quality experience:

- **Appearance:** Dress as you would for an in-person session
- **Setting:** Opt for a chair or couch; sessions are not suitable for clients situated on a bed or floor
- **Privacy & Safety:** Choose a well-lit, private, and secure location for your session. Avoid bathrooms
- **Camera Position:** Ensure device's camera is directed towards the client
- **Engagement:** Dedicate your full attention to the session, staying present, alert, and actively participating
- **Guest Policy:** Only include others in the session if previously discussed and approved by your provider
- **Avoid Multitasking**: Refrain from simultaneous activities like driving, shopping, or any distracting actions during the session
- **Punctuality**: Be prepared to begin at the scheduled time, recognizing that providers adhere to strict timelines
- **Recording**: Always seek your provider's consent before recording any part of the session

Non-adherence to these guidelines might lead to session interruptions, potential charges for missed appointments, or the need to reschedule for in-person consultations.

By proceeding with Telehealth services, I acknowledge and commit to upholding the above standards.

_____

Name of Child

_____

Name of Parent/Guardian

_____ _____

Signature of Client/ Parent Guardian Date

CHAMPIONED MINDS
BEHAVIORAL HEALTH

INFORMED CONSENT, HIPAA, GRIEVANCE PROCEDURE, AND CLIENT RIGHTS

I hereby attest to have read and received a copy of the Notice of Informed Consent document, as well as this HIPAA and CLIENT RIGHTS form. I acknowledge that I have both read and understood all the terms and information contained herein and agree to abide by its terms and conditions. Ample opportunity has been offered to me to ask questions and to seek clarification of anything unclear to me. **By signing this form, I also acknowledge that I was given a copy of my HIPAA notice, Client Rights form and how to file a grievance.**

_____

Name of Child

_____

Name of Parent/Guardian

_____ _____

Signature of Client/ Parent Guardian Date

CHAMPIONED MINDS
BEHAVIORAL HEALTH

FEDERAL REGULATION: CONFIDENTIALITY OF CLIENT RECORDS (42 C.F.R)

In accordance with 42 C.F.R alcohol and other drug client records are subject to the follow confidentiality conditions: This agency complies with these requirements. Program staff shall not convey to a person outside of the program that a client receives services from the program or disclose any information identifying a client as an alcohol or other drug services client unless the client consents in writing for the release of information, the disclosure is allowed by a court order, or the disclosure is made to a qualified personnel for a medical emergency, research, audit or program evaluation purposes. Federal laws and regulations do not protect any threat to commit a crime, any information about a crime committed by a client either at the program or against any person who works for the program. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or Local authorities.

_____

Name of Child

_____

Name of Parent/Guardian

_____ _____

Signature of Client/ Parent Guardian Date

CHAMPIONED MINDS
BEHAVIORAL HEALTH

AUTHORIZATION FOR BILLING

I hereby authorize the disclosure and release of certain information to facilitate billing for services provided by Championed Minds. I understand that this information may be disclosed to the following individuals/organizations:

Authorized Individual/Organization to Make Disclosure: Championed Minds

Authorized Individual/Organization to Whom Disclosure is Made: Change Healthcare and Covering Insurance Agency

Purpose of Disclosure: To facilitate billing for services

Type of Information to be Disclosed:

- Progress Notes
- Diagnostic Assessment Information
- Progress in Treatment
- Lab Results
- Urine Screen Results
- Diagnosis
- Information on Mental Illness and/or Treatment
- Treatment dates and duration

I authorize the release of any information necessary to process claims with my insurance company, and I authorize my insurance company to make payments for my treatment directly to Championed Minds.

By signing below, I acknowledge that I have read and understood the terms of this Authorization for Billing Disclosure Form, and I consent to the disclosure of the specified information for the purposes described herein.

_____

Name of Child

_____

Name of Parent/Guardian

_____ _____

Signature of Client/ Parent Guardian Date

CHAMPIONED MINDS
BEHAVIORAL HEALTH

AGENCY FEE SCHEDULE

As a Championed Minds client, the following fees apply for services received.

Service	Mental Health Fees	SUD Fees
Assessment	$111.11 - $130.72	$111.11 - $130.72
Case Management SUD (15 mins)		$19.54
Urine Screening		$14.48
Group Counseling IOP Level of Care		$103.04 - $149.88
Individual Psychotherapy 60+ mins	$102.31	
Individual Psychotherapy 45 mins	$69.74	
Individual Psychotherapy 30 mins	$53.64	
TBS Services (15 Minutes)	$19.96 - $28.59	
Group TBS Services	$4.99 - $5.62	
Day Treatment Services up to 2 hrs	$18.85 - $28.10	
Day Treatment Services Per Diem	$104.55 - $140.51	
Community Psychiatric Supportive Treatment (15 mins)	$19.54	

Fee schedule rates are determined and updated by the Ohio Department of Medicaid on an annual basis. For additional information, visit https://medicaid.ohio.gov/resources-for-providers/billing/fee-scheduleand-rates

_____

Name of Child

_____

Name of Parent/Guardian

_____ _____

Signature of Client/ Parent Guardian Date

CHAMPIONED MINDS
BEHAVIORAL HEALTH

NOTICE OF PATIENT FINANCIAL RESPONSIBILITY

Billing and Insurance: As courtesy to our patients to verify the mental health benefits with your insurance carrier. To do so, we must obtain a copy of your insurance card and obtain the name, address, and birth date of the subscriber. The information that we receive is not a guarantee of payment. We recommend that you reference your mental health benefits policy or consult your insurance carrier directly with questions regarding benefits and participation.

In addition, Championed Minds will bill your insurance carrier for services provided. All co-payments are due at the time of service. Co-insurance, deductibles, and any outstanding balances will be due upon receipt of our billing invoice.

Payment Options: Championed Minds accepts cash, checks, and money orders for self-pay clients. Monthly payment plans may be arranged.

Collections Policy: We are committed to assisting our patients in fulfilling their financial responsibilities. Our team endeavors to provide support and options to accommodate individual financial circumstances. However, should a patient fail to respond to our billing notices or refrain from making a definitive payment arrangement, we must reserve the right to initiate an involuntary discharge process. Following this, any unresolved account balances may be forwarded to a collection's agency for further action. We take this step as a last resort and after all attempts at reaching a mutually agreeable solution have been exhausted.

_____

Name of Child

_____

Name of Parent/Guardian

_____ _____

Signature of Client/ Parent Guardian Date

CHAMPIONED MINDS
BEHAVIORAL HEALTH

DISCHARGE AND TRANSITION PLANNING ACKNOWLEDGEMENT

I hereby acknowledge that I have reviewed and understand the Discharge and Transition Planning policy outlined below, which applies to my engagement with "Championed Minds" (the Agency) for mental health services. I recognize the importance of distinguishing between involuntary discharge and voluntary discharge, with involuntary discharge potentially arising from factors such as multiple missed appointments, unresponsiveness, or safety concerns.

Voluntary Discharge: I understand that voluntary discharge occurs when I, as the client, feel that the goals outlined in my Individualized Care Plan (ICP) have been achieved, and I am equipped to maintain my well-being independently. I also acknowledge that I have the right to request the discontinuation of services at any time, and the Agency will respect my decision.

Involuntary Discharge: I recognize that involuntary discharge may result from situations such as multiple missed appointments, lack of communication, safety concerns, or other factors determined by the Agency's clinical team. In such cases, the Agency will make every effort to address my well-being, ensure continuity of care, and provide referrals or resources if necessary.

I have been informed of the Discharge and Transition Planning policy and understand the distinctions between voluntary and involuntary discharge as outlined above.

_____

Name of Child

_____

Name of Parent/Guardian

_____ _____

Signature of Client/ Parent Guardian Date

CHAMPIONED MINDS
BEHAVIORAL HEALTH