Lindner Center of HOPE | UC Health

Name: _____

Appointment Date/Time: _____

Practitioner: _____

The Lindner Center of HOPE would like to welcome you to our Outpatient Practice!

The Lindner Center of HOPE addresses the diagnosis and treatment of mental illnesses through the provision of a wide range of outpatient treatment programs for patients across the age spectrum, including children as young as two years old, adolescents, adults and senior adults. Outpatient care at Lindner Center of HOPE establishes an individualized treatment program that uses a combination of the newest protocols and proven techniques. Patients participate in meaningful individual or family therapy while maintaining normal life activities.

The Lindner Center of HOPE Outpatient Practice welcomes new and established Medicare patients for consultations, second opinions, medication management and psychotherapy. These services are provided by a group of leading mental health providers. Registration staff will verify whether your insurance plan is in or out of network.

Co-insurance fees, co-pays, deductibles, out-of-network balances, or fees for services not covered by insurance will be collected at the point of service. All non-covered and self-pay patients, fees are collected at the point of service. Fees vary by clinician and specialty.

Included in this packet are forms that need to be completed and brought with you to your first appointment. You will also need to bring your insurance card(s) and picture identification with you so that we can make a copy for your record. Be sure to arrive at least 20 minutes prior to your first appointment to allow time to complete your registration. The outpatient check in department is located in the main lobby level of the hospital (look for the signs that say Registration).

Please contact our outpatient department at **513-536-0600 (Select option 1 for new patients)** if you have any questions about the information in this packet.

Thank you.

To learn more about the Lindner Center Of HOPE, visit our website at www.lindnercenterofhope.org
Main Phone Number:
513-536-HOPE (4673)

Lindner Center of HOPE | UC Health

Map to Lindner Center of HOPE

Lindner Center of HOPE
4075 Old Western Row Road
Mason, Ohio 45040

513-536-4673

Lindner Center of HOPE | UC Health

Directions to Lindner Center of HOPE

Directions from I-71 heading north

- Take the Western Row exit (exit #24.)
- Turn left at the first traffic light (Western Row Rd.)
- Travel 0.7 mile to Western Row/Tylersville Road traffic light
- Turn left at traffic light.
- Travel 1 block
- Turn left at Old Western Row to 4075 Old Western Row which is on the right
- Follow LCOH driveway to the Center

Directions from I-71 heading south

- Take the Kings Mills exit (exit #25.)
- Turn left at the first traffic light (Kings Mills Rd.)
- Travel to second stoplight and turn right on Kings Island Drive
- Follow Kings Island Drive past Kings Island to Western Row Road; turn right
- Travel 1 block
- Turn left at Old Western Row to 4075 Old Western Row which is on the right
- Follow LCOH driveway to the Center

Directions from I-75

- Take the Tylersville exit (exit #22) and head east (left from north; right from south)
- Travel approximately 4.5 miles through Mason to Western Row/Tylersville traffic light
- Turn right at traffic light
- Travel 1 block
- Turn left at Old Western Row to 4075 Old Western Row which is on the right
- Follow LCOH driveway to the Center

Parking

There is ample free parking at the Center in the Visitor parking lots.

Contact Information

For General Information

Call 513-536-HOPE (4673)
888-536-HOPE (4673)

All new patients

Call 513.536.0536.

Intake Specialists will help assess your needs and work with you to help determine the best options for care.

It is important to understand the terms and conditions of your insurance. Please contact your insurance company or employer to confirm your coverage and possible financial obligation.

For more information about Lindner center of HOPE visit our website at www.lindnercenterofhope.org

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CONSENT FOR OUTPATIENT TREATMENT & FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ **MR#** _____ **Date:** _____

CONSENT TO TREATMENT

The undersigned, patient/patient's legal guardian, voluntarily consent to outpatient treatment for ☐ mental health, ☐ co-occurring and/or ☐ substance use and authorizes the Lindner Center of HOPE (LCOH) to provide such outpatient treatment that is determined to be medically necessary or otherwise appropriate. These services may include individual or group counseling/therapy, Pharmacologic Management Services, Diagnostic Assessment, Psychological Testing. Services at LCOH will be provided by a multidisciplinary team that may include one or more of the following: psychiatrists, psychologists, independent licensed social workers, certified chemical dependency counselors, advanced practice nurses, case managers, and experiential therapists.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned hereby permits LCOH, and/or their authorized personnel, to access and/or release all or any part of the patient information (including information regarding drug/alcohol treatment, HIV testing, AIDS and mental health treatment) to, including but not limited to, the appropriate healthcare insurer(s), third party payer(s), and/or the LCOH 's agent(s), attorney(s) and/or consultant(s) for purposes including improving patient care, performance improvement initiatives, discharge planning, risk management, collection agencies, regulatory and licensing agencies and/or as required by law.

RESEARCH FACILITY

I understand that LCOH is a research facility. As such, I grant the LCOH research treatment team access to my or the patient's records to determine if I or the patient may be eligible for a current or potential study. This consent involves only the review of records, and additional information and consents would be provided in the event that I or the patient would be considered for the study.

MEDICARE PAYMENT

I, the undersigned, certify that any information given by me in applying for payment under Title XVII of the Social Security Act is complete, accurate, and current. As a Medicare Beneficiary, I have the right to receive Medicare covered services. This includes medically necessary services. I acknowledge that I have the right to be involved in any decisions about my treatment and services and who will pay for them.

WAIVER OF LIABILITY FOR NON-APPROVED SERVICES

Ohio law requires LCOH to inform the undersigned that if your insurance company did not give prior approval for medical services and you choose to have the services provided, you would be required to pay for the services. My signature acknowledges I have read and understand the above. If my insurance company denies payment, I agree to be personally and fully responsible for the payment of all services incurred.

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

In consideration of services received or to be received, the undersigned requests that payment of authorized insurance benefits, including Medicare, if the patient is a Medicare beneficiary, and including Medicaid, if the patient is a Medicaid beneficiary, be made on the patient's behalf to LCOH for any services provided to the patient. It is my responsibility to notify LCOH of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by LCOH and/or my health care insurer if the submitted claims or any part of them are denied for payment. The undersigned acknowledges that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

The Lindner Center of HOPE appreciates the confidence you have shown in choosing us to provide health care services to you, or a patient of the Center for whom you have responsibility. Our patient- and family-centered treatment philosophy requires that we openly communicate our policies and expectations about payment for our services before treatment is initiated. Please take a moment to familiarize yourself with these policies.

I acknowledge that I am financially responsible for all charges associated with health care services provided by the Center to me (or the patient named below). I understand that payment for services is due at the time services are rendered unless special arrangements are made in advance.

Insurance: (Please check the appropriate box)

☐ I do have insurance that provides coverage for mental health and/or alcohol/drug treatment services. I am requesting the Center bill my insurance provider. I agree to pay all deductibles, co-payments, and/or co-insurance associated to the services I receive at LCOH.

-or-

☐ I do not have insurance that provides coverage for mental health and/or alcohol/drug treatment services.

-or-

☐ I request that whether or not I (or the patient named below) have insurance that may provide coverage for mental health services, the Center not bill my insurance company for privacy reasons. I acknowledge that my request that the Center not bill my insurer creates a personal financial obligation on my part.

☐ I understand that the service I am having at LCOH is out of network and I fully understand that my insurance will pay at a reduced rate or will pay nothing if I do not have out of network benefits.

Late Cancellations, Missed Appointments or Telephonic Services: I understand that I am required to provide at least 24 hours advance notice if I (or the patient named below) am unable to keep a scheduled appointment. In the event that I do not provide 24 hours advance notice, I acknowledge that the Center has the right to charge me for the scheduled appointment. If I fail to cancel a scheduled appointment, and do not come to the Center at my (or the patient's) scheduled appointment time, I understand that the Center will charge me for the scheduled appointment. I agree to pay the Center any late cancellation, missed appointment charges or telephone charges incurred.

Returned Check Fee: The Center may, in its discretion, charge a fee for any check returned by my financial institution, regardless of reason. In such event, I agree to pay the Center a returned check fee of up to $35.00.

Delinquent Account: I understand that the Center may turn my account over to a collection agency if I do not pay on a timely basis. The Center has a separate collection policy, which will be provided to me if I ask for it.

Credit Card Payments: I may request, as a convenience, that the Center charge my credit card for any charges discussed in this agreement. Credit card must be presented at the time of each service.

CONTACT RECORD

In the event it becomes necessary, please contact me as follows (check at least one):

- ☐ Home/Cell Telephone (_____) _____
- ☐ Work Telephone (_____) _____
- ☐ Leave message with call-back number only
- ☐ Do not leave message
- ☐ Written Communication - Mail to my home address
- ☐ Leave message with appt. date & time
- ☐ Leave message with appt. date & time

OTHER INFORMATION

I, the undersigned, agree to abide by LCOH's policies and procedures and recognize that my compliance will minimize the danger of accidents or injury to myself, other Patients, and employees of LCOH. I, the undersigned, acknowledge responsibility for myself and my actions and liability arising or resulting from my acts/omissions while I am being treated at LCOH. I, the undersigned, acknowledge that LCOH is not responsible to me or my property for the acts/omissions or any liability arising from the acts/omissions of any other patients at LCOH.

I, the undersigned, understand that at any time I may elect to participate in other services or refuse any services, treatment or therapy upon full explanation of the expected consequences of such refusal.

I have received a copy of the Outpatient Handbook _____ (date), which include the patient rights and grievance policy, Notice of Privacy Practice, an explanation of the risks & benefits of treatment, alternative treatments, and of no treatment. _____ (initial)

DISCLOSURES:

I the undersigned, attest that I am not a registered sex offender of any state._____ (initial)
I, the undersigned, am not seeking criminal court appointed mental health treatment or evaluation or as a condition of my probation or parole._____ (initial)

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE.

I am the patient or am authorized to sign this document. I have read and understand this Consent for Outpatient Treatment.

Signature of Patient or Legal Guardian: _____ Date:_____

Printed Name of Patient or Legal Guardian: _____

Relationship of Legal Guardian to Patient: _____

Signature of Financially Responsible Party: _____ Date:_____

LCOH Witness Signature: _____ Witness Date: _____

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OUTPATIENT SERVICES
ACKNOWLEDGEMENT OF PATIENT INFORMATION

Patient Name: _____ DOB: _____

SS#: _____ MR# _____

By signing this form, I am acknowledging that I have received a copy of the information listed below.

1. Consent for Outpatient Treatment
2. Outpatient Handbook, which includes:
   - Patient's Rights
   - Grievance Policy and Process
   - HIPAA Notice of Privacy Practices
   - Safety Information
   - Lindner Center of HOPE Treatment Rules
   - Risks and Benefits to Treatment
3. Lindner Center of HOPE Program Specific Rules, as applicable
4. Physician/Clinician-Patient E-Mail Consent Form

Questions may be directed to your primary clinician.

Cost for Treatment: (prior to insurance and self-pay liability)

Psychiatric Assessment	$370
Psychotherapy, up to 16 - 37 minutes	$90
With Evaluation & Management	$100
Psychotherapy, up to 38 - 52 minutes	$140
With Evaluation & Management	$200
Psychotherapy, up to 53+ minutes	$250
With Evaluation & Management	$310
Outpatient Family Therapy	$180
No Show Fees	$ 50-$100
Intensive Outpatient (IOP)	$570

_____ _____
Patient/Guardian Signature Date

_____
If guardian, relationship to patient:

_____ _____
Staff Signature Date

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AUTHORIZATION FOR THE RELEASE OF PATIENT PROTECTED HEALTH INFORMATION

PATIENT INFORMATION (Please Print) MR # _____

_____ _____ _____
Last, First, MI | Date of Birth | Social Security Number

_____ _____
Address, City, State, Zip Code | Phone #

PROTECTED HEALTH INFORMATION (PHI) TO BE OBTAINED OR DISCLOSED

Check boxes to indicate the PHI that may be obtained or disclosed:

INPATIENT Dates of Service:_____ **and/or Outpatient Dates of Service:**_____

☐ Outpatient Assessment	☐ Patient Follow-up Report	☐ Discharge Summary	☐ Laboratory Reports
☐ Inpatient Assessment	☐ Physician Orders	☐ MRI Reports	☐ Social Work Assessment
☐ Medical History & Physical	☐ Consultation Reports	☐ ECT Record	☐ Progress Notes _____
☐ Psychological Testing Reports	☐ Treatment Plan	☐ TMS Record	☐ Nursing Assessment

☐ Other: _____

☐ **Disclosure Records To:** ☐ **Obtain Information From:**

_____
Individual/Agency/Hospital

_____
Address, City, State, Zip Code

_____ _____ _____
Phone Number | Fax Number | Reason for Disclosure (ie. Medical, Attorney, Personal)

I, the undersigned, authorize Lindner Center of HOPE, 4075 Old Western Row Road, Mason, OH 45040 to use and/or disclose information from my medical or financial record as specified above.

I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include documentation of treatment for mental health disorders, alcohol/drug abuse or dependence, and/or HIV/AIDs test results or diagnosis. I expressly consent to the release of information as designated above. Furthermore, I consent to the release of the facsimile transmission of my protected health information as necessary.

This authorization will expire in six (6) months unless otherwise specified. I understand that I or my legal representative may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance of this authorization. I also understand that Lindner Center of HOPE may charge a reasonable fee for the preparation, copying and postage as allowed by state law for copies of medical records.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits, unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

I understand that if the person/entity that receives the above PHI is not a health care provider/health plan covered by federal privacy regulations, the PHI described above may be re-disclosed by such person/entity and will likely no longer be protected by the federal privacy regulations.

_____ _____
Patient Signature (if 18 years of age or older) | Date

_____ _____
Signature of ☐ Parent ☐ Legal Guardian (check one) | Date

_____ _____
Witness | Date

This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as other wise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

STAFF USE

Request Has Been Fulfilled by: ☐ HIM ☐ OPP ☐ Unit ☐ Social Worker / Staff Name: _____ Initials: ____ Date: _____

Sent by: ☐ Fax ☐ Mail ☐ Picked up Driver's License: _____