ATTENTION PATIENTS OF DOMINION OUTPATIENT SERVICES:

1. If you miss or cancel 3 appointments without giving 24 hours' notice, you will be discharged from Dominion Outpatient Services (DOS). This will also mean we are not able to fulfill refills on medication. **ALL CANCELATIONS MUST BE MADE 24 HOURS PRIOR TO SCHEDULED APPOINTMENT TIME.**

2. Refills will not be granted after 5pm, on weekends, or holidays.
3. Refill requests can take a minimum of 3 business days.
4. In order to ensure you do not run out of medications, you will need to submit a refill request at least one week prior to their due date. Your pharmacy should be contacting the office at least a week ahead of when you will need your medication to ensure you do not run out. Many pharmacies also allow you to subscribe to automatic refill reminders.
5. Your Insurance card must be available at every appointment. You may to be able to keep your appointment if we cannot verify your insurance.
6. For clients that have commercial insurance, all requested clinical documentation needed will be charged $20 per page Clinical documentation requires 2 weeks preparation time (IE: Letters for school, court, or attorneys). This does not include doctor's notes for attending appointments at DOS.
7. Calls received outside business hours will be returned the next business day. If you are having suicidal ideations or are concerned for you or your child's safety, please contact the nearest ER or dial 911.

____

Client or Guardian Signature Date

DOMINION OUTPATIENT SERVICES

Rights and Responsibilities

You are entitled to certain rights under Federal and State Laws. No person shall be denied any of their legal rights while you are receiving services from Dominion Youth Services. Such rights include, but are not limited to, the following:

1. The right to be treated with dignity and respect and to use your preferred or legal name.
2. The right to privacy
3. The right to equal access to treatment or services regardless of race, religion, sex or handicap
4. The right to inquire and be told about your rights.
5. The right to a fair and objective grievance process.
6. The right to participate in the development of your treatment/service plan.
7. The right not to be the subject of experimental or investigational research without written and informed consent.
8. The right to be fully informed of treatment involving significant risks.
9. The right to receive confidential services and your record to be kept in a confidential manner within the limits of the law and have appropriate access to those records.
10. The right to receive services in the least restrictive environment.
11. The right to have a copy of the rules of conduct applicable to services in which you are participating.
12. The right to receive services in a manner that is responsive to your age, gender, family, friends, cultural/ethnic background, sexual orientation, mental/physical disability and spiritual beliefs.
13. The right to know that your clinician may be a Supervisee registered with the Board of Health Professions. If so, their name and credentials and supervisor will be given to you separately.

IF YOU FEEL YOUR RIGHTS HAVE BEEN VIOLATED, TALK WITH:
Lauren Sowers, Program Director, 540-419-3958
IF YOU FEEL THAT YOU NEED ASSISTANCE OUTSIDE OF OUR AGENCY, PLEASE CONTACT THE LOCAL HUMAN RIGHTS COMMITTEE AT (877) 600-7437.

____

Individual's Signature (if applicable) Date

____

Signature of Legal Guardian or Primary Caregiver (if applicable) Date

____

Signature of DOS Staff Date

DOMINION OUTPATIENT SERVICES
INDIVIDUAL ORIENTATION CHECKLIST

Individual's Name: _______________________________ Individual's ID #: ________________

During orientation, the following items were discussed:

- Mission of program and services provided
- Confidentiality policy
- Provider choice option
- Human rights
- Attendance and service policies
- By signing below client and the legal guardian or primary care giver (if applicable) agree that they have received a copy of Dominion Outpatient Services rights and responsibilities to include a list of service guidelines.
- Any complaints should be addressed to your therapist
  If you feel that you need outside assistance please contact the regional advocate, Michael Curseen at 804-524-7245
- Client primary caregiver and DOS staff will collaborate together in the development of client's treatment plan
- Availability of after-hours services and crisis services resources
- Termination planning

Please sign below to indicate that the policies and procedures listed above were discussed with you.

____

Individual's Signature (if applicable) Date

____

Signature of Legal Guardian or Primary Caregiver (if applicable) Date

____

Signature of DOS Staff Date

DOMINION OUTPATIENT SERVICES

Service: DOS | City/State: | Date:

Therapy Attendance Policy

Attending sessions regularly is an important component of the therapeutic process. Therapists at this agency also understand that occasionally there are situations that may arise that can cause you to miss an appointment. If you are unable to attend a therapy appointment, please contact your therapist by phone within 24 hours of the appointment.

If you miss two consecutive therapy appointments and did not contact your therapist prior to the missed appointments, a letter will be sent to you regarding possible termination of services. You will have 5 business days to respond to this letter. Please note that if you miss three consecutive therapy appointments without prior cancellation of these missed appointments it is the policy of Dominion Outpatient Services, LLC, that your therapist will send a termination letter notifying you that the therapeutic services will not be able to continue services until you're ready to reenroll in services.

I, the undersigned, have read the Attendance Policy and understand that if I fail to attend and adh ere to this attendance policy, my case will be placed in termination status.

____
Individual's Signature (if applicable) Date

____
Signature of Legal Guardian or Primary Caregiver (if applicable) Date

____
Signature of DOS Staff Date

Dominion Outpatient Services, LLC
Rights to Confidentiality

We take confidentiality very seriously. We follow very strict rules from the United States and State Governments about when we can release your medical record and your protected health information.
PLEASE REVIEW THIS NOTICE CAREFULLY.

The Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule establishes a foundation of Federal protection for personal health information, carefully balanced to avoid creating, unnecessary barriers to the delivery of quality health care. The Rule generally prohibits this program from using or disclosing your protected health information unless authorized by you, except as follows:

First, we are required by law to disclose your protected health information in certain circumstances, for example, to report abuse and neglect and to warn about dangerous behavior. Second, we are authorized to disclose your protected health information without your consent when we use the information for treatment, payment, or the health care operations of this program.

Treatment generally means the provision, coordination, or management of health care and related services among health care providers or by a health are provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

Payment encompasses the various activities of health care providers to obtain payment or be reimbursed for their services.

Health care operations are certain administrative, financial, legal and quality improvement activities of a program that are necessary to run its business and to support the core functions of treatment and payment.

The program will, without your authorization:

1. Use or disclose your protected health information for its own treatment, payment, and health care operations activities.
2. We may disclose your protected health information for the treatment activities of any health care provider (Including providers not covered by the Privacy Rule)
3. We may disclose your protected health information to another health care provider (including providers not covered by the Privacy Rule) for the payment activities of the entity that receives the information.
4. We may disclose your protected health information to another provider for certain health care operation activities of the provider that receives the information if:

    Each Provider either has or had a relationship with you, and protected health information pertains to the relationship; and

    The disclosure is for a quality-related health care operations activity or for the purpose of health care fraud and abuse detection or compliance.

Security. Your medical record (your protected health information) is kept in a secure location and only those employees or clinicians who need access to your medical record for treatment, payment or health care operations have access to your medical record unless you sign an authorization.

It is our policy to reasonably limit disclosures of, and requests for, protected health information for payment and health care operations to a minimum necessary. We also limit which members of our workforce may have access to protected health information for treatment, payment, and health care operations based on those who need access to the information to do their jobs.

We may also disclose information in order to contact you, for example to make appointments, to check with you about how you are doing, and to evaluate the services that we provide to you. We may also contact you for our fun-raising efforts.

Your right to see your record

You have the right to see your record, or to receive a summary of your record. To do this, please contact your Service Provider. You also have the right to ask us for an accounting of the persons or programs to whom we have disclosed your protected health information (This does not include disclosures for treatment, payment or health care operations, or to persons authorized by you.) To receive this accounting, please contact your care provider.

If you disagree with the contents of your medical record, you may also request an amendment to your record. We will place that amendment in the medical records unless we did not create that part of the record or we believe the existing record is accurate and complete. If we grant the amendment, we will notify you and you may request that we provide the amendment to other programs and to programs that you identify to us as having already received your medical record. If we deny the amendme nt, we will give you specific reasons for the denial. You may then submit a statement of disagreement and we may submit a rebuttal. If you notify us in writing, we will attach your request for amendment and our denial to future disclosures of that part of your medical record. Also, if you continue to disagree, you may file a complaint with Lauren Sowers, Program Director with Dominion Youth Services or file with the Complaint Officer with the Office of Civil Rights at HHS.gov.

How to file a complaint

If you believe that your protected health information has been released in violation of the law, you have the right to file a complaint. You may file a complaint with our program by contacting or submitting a letter to: Lauren Sowers, Program Director at 2004 Bremo Rd. suite 101 Richmond, VA 23226. You may also file a complaint with the Office of Civil Rights at HHS.gov. You have our promise that our program will not retaliate against you if you choose to file a complaint.

If you want to send your protected health information to someone, you must sign an authorization.

Authorizations may be obtained from your Service Provider.

Notification of Breach:

In an event there has been a breach in releasing personal health information (PHI), Dominion Outpatient Services will provide notice to you by telephone or verbally by Dominion Outpatient Services. Such conversation shall be documented by Dominion Outpatient Services.

My signature below indicates that I have read the above Notice of Privacy Practices and Notification of Breach of the Agency and understand that I may request a copy of this notice at any time.

____
Signature of Patient/Client Date

____
Signature of Parent, Guardian or Personal Representative Date

DOMINION OUTPATIENT SERVICES

Service: DOS **City/State:** **Date:**

PROVIDER CHOICE/DMAS APPEAL PROCESS
(Medicaid and Medicare Only)

Individual's Name______________________________________Individual ID:___________

If you are an individual or an individual's legal guardian seeking the service listed below, you are entitled to a choice of provider. This means you may select Dominion Outpatient Services as your provider or you may choose from another provider within the community. In addition, any action taken by this agency may be appealed to the Department of Medical Assistance Services (DMAS) by following the procedures listed below.

- The freedom of choice has been discussed with me. I understand that I have the option to receive services from other providers, but choose Dominion Outpatient Services as my provider for the following service:

Outpatient Therapy

- The freedom of choice has been discussed with me, and I have chosen to receive this service from another provider in the community. I understand that Dominion Outpatient Services has no obligation to cover the costs of those services.

Any action taken by this agency that affects the services of this individual may be appealed to DMAS. Your notification must be written and submitted to the Appeals Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. The written request for an appeal must be filed within thirty (30) days of this notification. If you file an appeal before the effective date of this action, (date), services may continue during the appeal process. However, if this decision is upheld by the appeals division, you will be required to reimburse the Medical Assistance Program for services provided after (date). For further information on recipient rights, you may call 804-786-7933 or visit them on the website at www.dmas.virginia.gov/.

By signing below, I agree that the freedom of choice and the appeals process of the Department of Medical Assistance services has been discussed with me.

____

Individual's Signature (if applicable) Date

____

Signature of Legal Guardian or Primary (if applicable) Date

____

Signature of DOS Staff Date

Informed Consent

I, __________________________ consent to participate in mental health services offered and provided by Dominion Outpatient Services, LLC. I understand that I am agreeing to only those services that the above provider is qualified to provide within:

1. The scope of the provider's license, certification, and training
2. The scope of the provider's license, certification, and training of the mental health provider's directly supervising the services received by the client

If the client is under the age of 18 or is unable to consent to treatment and/or legally authorized to initiate or consent to treatment on behalf of this client

____

Individual's Signature (if applicable) Date

____

Signature of Legal Guardian or Primary (if applicable) Date

____

Signature of DOS Staff Date

Dominion Outpatient Services
Telehealth Services Consent

Treatment Services
I agree to take part in Telehealth services offered by Dominion Outpatient Services Telehealth potential risks and benefits were explained to me. Program staff also explained how the telehealth services work.

Use of Telehealth
I understand that I may be seen by a therapist or Nurse Practitioner in person or remotely at Dominion Outpatient For remote services, I hereby authorize Dominion Youth Services to use Telehealth in the course of my assessment and treatment. I understand that the Telehealth involves the communication of my medical information, both orally and visually, to staff and other healthcare practitioners who are not physically present at the program's site.

What is Telehealth and how do Telehealth Services work?
Telehealth services are used when the provider cannot be physically present with you to evaluate your needs and service plan. Telehealth allows you and the staff to talk with and see one another using video and computer equipment.

You will be in a private room with a staff person over video/phone. You may also request to have a friend or family member present. The staff will be in a private room at another location also with a computer and video camera.

Client Choice
I understand that I have the option to withhold consent at this time or to withdraw this consent at any time, including any time during a session, without affecting the right future care, treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

If I choose not to consent to Telehealth services, the program may be unable to provide me with the convenient and readily available services and my services will be rescheduled for a later date and/or a different site.

Benefits & Risks of Telemedicine
I understand that I can expect benefits from Telehealth but that no results can be guaranteed or assured. Telehealth provides me access to behavioral health care that otherwise might not have been available in my community. Despite reasonable and appropriate efforts, there is the possibility that:

- The transmission of medical information could be disrupted or distorted by technical failures in transmission;
- The transmission of medical information could be interrupted by unauthorized persons;
- The electronic storage of medical information generated by telemedicine consultation in one or more databases could be accessed by unauthorized persons;
- Telemedicine sessions or care may not be as complete as face-to-face exams or care;
- Telemedicine does not negate or minimize the risks that may be inherent in a medical/mental illness or condition.

I understand that it is impossible to list every possible risk, that my condition many not be cured or improved, and in rare cases, may get worse.

Communication with Healthcare Practitioners
I understand that by consenting to Telehealth, my staff will communicate medical information concerning me to physicians and other healthcare practitioners as permitted by HIPAA regulations protecting my confidentiality and privacy (see Client Notice of Privacy Practices). All existing confidentiality protections apply. All existing laws regarding client access to mental health information and copies of mental health records apply. There is no permanent video or voice recording kept of the Telemedicine service's session. Client identifiable images or information from the Telehealth interaction shall not occur without the consent of the client or as otherwise permitted by law.

I have read and agree to all conditions for treatment and Telehealth set forth herein. I acknowledge that I have received a copy of this agreement.

Client: ______________________________ ________________________________
Print Name Signature

Parent/Guardian (if applicable): ____

Staff / Witness ____

DOMINION OUTPATIENT SERVICES

Service: DOS **City/State:** **Date:**

Individual's Name_______________________________________ Individual ID: ____________

FINANCE AGREEMENT

In accordance with the services that will be provided by Dominion Outpatient Services, LLC, I hereby agree and authorize my insurance company to pay this agency in full for services rendered in accordance with my medical benefits as agreed to in my insurance policy. I hereby authorize Dominion Outpatient Services, LLC, to release to my insurance company any information necessary for seeking reimbursement for the services listed below.

FEE SCHEDULE

Initial evaluation (90 minutes)	$130.00
Individual Therapy Session (45 to 50 minutes)	$90.00
Family therapy session	$90.00
Psychiatric Evaluation	$225.00
Medication Management	$75.00
Missed Appointments	$50.00

CO-PAYMENTS

All applicable co-payments, deductibles, or any other out of pocket expenses are expected to be paid at the time of the appointment. The co-payment is your responsibility and payments are expected at the time of your appointment unless your insurance coverage requires another arrangement. Payment is accepted only by cash or check. Dominion Outpatient Services, LLC, reserves the right to increase fees in the future to a reasonable amount and you will be given adequate advance notice if this should occur.

My Insurance company is:___________________________________.

The amount of my co-payment is ____________as assigned by my insurance company.

MISSED APPOINTMENTS

I understand that it is my responsibility to schedule and ensure that appointments are kept. I understand that if I am unable to attend my scheduled appointment that I must call, cancel, and reschedule my appointment within 24 hours of that appointment. I understand that I will be held responsible for any appointment that is not cancelled with 24-hour notice. I also understand that my insurance company will not pay for missed appointments and that I may be asked to pay the full fees for services rendered as stated in the above fee schedule.

INSURANCE PROCESSING

Your insurance company may require that you pre-authorize your treatment with us prior to your visit. It is your responsibility to monitor insurance benefits, deductibles, as well as effective and termination

dates of coverage. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have any questions, please contact your plan administrator. Feel free to speak with your therapist and/ or psychiatrist if assistance is needed with this.

By signing below, the undersigned affirms that you have read, understands and agrees to the finance agreement as outlined above. I authorized my insurance company to make payments directly to Dominion Outpatient Services, LLC for services rendered.

____
Individual's Signature (if applicable) Date

____Signatur
e of Legal Guardian or Primary (if applicable) Date

____
Signature of DOS Staff Date

DOMINION DAY SERVICES
AUTHORIZATION FOR RELEASE/EXCHANGE INFORMATION

Service: DOS **City/State:** **Date:**

Individual's Name____ DOB:____________

Social Security Number:________________________

This information is to be released and/or exchanged between and among the identified agencies or persons solely for the purposes of obtaining accurate and complete history for agency records, and/or, for the process of consideration, treatment and follow-up related to participation in agency programs, including but not limited to clinical trial research, day treatment, and/or residential care. Any other use is strictly prohibited under federal law. I understand that the information may/will include treatment for mental and/or physical illness, and intellectual/developmental disability.

I hereby Authorize:

☐ Release to
☐ Obtain From
☐ Release to and Obtain from

Name, address and phone # of person or organization:
Name: ____
Address: ____
Phone: ____
Email: ____
Relationship to Client: ______________________________

Release Dates (Not to exceed one year)

Release takes Effect: ____________________
Release will End: ________________________
Records include a date range of ____________ to _____________.

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED:

☐Discharge Summary
☐ Psychological Evaluation
☐ History and Physical
☐ Admission Note
☐ Consultation
☐ Lab Reports (ECG, Blood Work, MRI/CT)
☐ Progress Notes
☐ Physician Orders
☐Social/ Occupational History
☐Medication Administration Record
☐Psychological Testing/Reports
☐Communications
☐Education
☐Psychiatric and/or Behavioral Health Records
☐Substance Abuse Treatment Records
☐Other

PURPOSE OF NEED FOR INFORMATION:

☐Evaluation/Treatment
☐Legal Purposes
☐Insurance/ Billing Purposes
☐Emergency Contact Information
☐Other

NOTE: I give permission to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse (Title CFR Part 2), and/or intellectual/developmental disability.

I hereby state that I have read and fully understand the above statements as they apply to me and do herein expressly consent to disclosure for the purpose or need and the extent or nature as stated above. I further understand that I may cancel this consent at any time to Dominion Youth Services, except where disclosure has already been made, or upon the occurrence of the event: the purpose for which the disclosure is hereby authorized. I further understand that refusal to allow disclosure may be considered in violation of my parole or probation.

NOTE: 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 this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Title 42 C.F.R Part 2. A general authorization for the release of medical or other information's NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

____
Individual's Signature (if applicable) Date

____Signatur
e of Legal Guardian or Primary (if applicable) Date

____
Signature of DOS Staff Date

☐ Please check if you wish to revoke this release information.

DOMINION DAY SERVICES
AUTHORIZATION FOR RELEASE/EXCHANGE INFORMATION

Service: DOS **City/State:** **Date:**

Individual's Name_______________________________________ DOB:____________

Social Security Number:_______________________

This information is to be released and/or exchanged between and among the identified agencies or persons solely for the purposes of obtaining accurate and complete history for agency records, and/or, for the process of consideration, treatment and follow-up related to participation in agency programs, including but not limited to clinical trial research, day treatment, and/or residential care. Any other use is strictly prohibited under federal law. I understand that the information may/will include treatment for mental and/or physical illness, and intellectual/developmental disability.

I hereby Authorize:

- ☐ Release to
- ☐ Obtain From
- ☐ Release to and Obtain from

Name, address and phone # of person or organization:
Name: ____
Address: _______________________________________
Phone: ____
Email: ____
Relationship to Client: _____________________________

Release Dates (Not to exceed one year)

Release takes Effect: ____________________
Release will End: ________________________
Records include a date range of _____________ to ______________.

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED:
☐Discharge Summary
☐ Psychological Evaluation
☐ History and Physical
☐ Admission Note
☐ Consultation
☐ Lab Reports (ECG, Blood Work, MRI/CT)
☐ Progress Notes
☐ Physician Orders
☐Social/ Occupational History

☐ Medication Administration Record
☐Psychological Testing/Reports
☐Communications
☐Education
☐Psychiatric and/or Behavioral Health Records
☐Substance Abuse Treatment Records
☐Other

PURPOSE OF NEED FOR INFORMATION:
☐Evaluation/Treatment
☐Legal Purposes
☐Insurance/ Billing Purposes
☐Emergency Contact Information
☐Other

NOTE: I give permission to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse (Title CFR Part 2), and/or intellectual/developmental disability.

I hereby state that I have read and fully understand the above statements as they apply to me and do herein expressly consent to disclosure for the purpose or need and the extent or nature as stated above. I further understand that I may cancel this consent at any time to Dominion Youth Services, except where disclosure has already been made, or upon the occurrence of the event: the purpose for which the disclosure is hereby authorized. I further understand that refusal to allow disclosure may be considered in violation of my parole or probation.

NOTE: 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 this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Title 42 C.F.R Part 2. A general authorization for the release of medical or other information's NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

____
Individual's Signature (if applicable) Date

____
Signature of Legal Guardian or Primary (if applicable) Date

____
Signature of DOS Staff Date

☐ Please check if you wish to revoke this release information.

Dominion Outpatient Services, LLC
Photo/Medica Consent Form

Written consent by the individual services or their substitute decision maker (custodial parent/authorized representative/legal guardian) will be obtained prior to DYS staff or agents engaging in photography, recording videos or audio tapes at/or for any agency sponsored events.

Recorded or printed images belong to DYS and when practicable, may be retained in the individual's medical record. Once information or images are made and disclosed, the service recipients' privacy may not be protected by federal privacy regulations.

All service recipients or substitute decision makers may revoke this authorization at any time, by notifying DYS staff, of their wish to do so. The individual or substitute decision maker will be notified of the receipt of the request.

My authorization (or the person receiving services, for whom I am giving consent) and voluntary consent to participate in a promotional sort or image (photograph, audio, video or media) made by DYS staff indicates my understanding that I have been told that this story and/or image (photograph, audio or videotape) may appear in the public media, including print or broadcast media and used for information, educational and/or training purposes. I agree that all such pictures, photographs, video recordings and any reproductions thereof, including digital files shall remain the property of DYS, unless otherwise notes. I may ask to review all final productions.

This consent Form terminates one year from the date of signature, unless revoked prior to that date.

I hereby:

☐ **Authorize and give my consent to participate in a promotional story or image**

☐ **Do not Authorize**

____
Individual's Signature (if applicable) Date

____
Signature of Legal Guardian or Primary (if applicable) Date

____
Signature of DOS Staff Date