5104 North Orange Blossom Trail. Orlando Florida 32810. Phone: 321 758 7186 OR
689 201 2702 Fax 407 250 0788 Web: www.ohollc.org

Optimum Health Outcomes, LLC
"Client Centric Focus on Total Wellness"

Welcome to care provided by Optimum Health Outcome. We provide Behavioral Health services. We are part of your primary care team, working with your health care provider, care managers, and psychiatry staff, if needed. To help direct our work with you, we will work together towards the goals described on your treatment plan. To help direct our work with you, we will work together towards the goals described on your treatment plan.

Our staff are a variety of providers. I understand that interns may also be used in collaboration with his/her supervisor

If you are not able to make appointments, you will need to call your assigned OHO staff member or (689 201-2702) to cancel. If you call in less than 1 working day, it may be considered a "no-show". If you have 3 "no-show" appointments during our sessions, then we may need to stop scheduling further appointments until we hear from you.

Your assigned OHO Staff Member is available by phone and email between appointments to answer questions you may have that cannot wait until we are to see you again. After hours are dependent upon the availability of your staff member.

If you are unable to contact our organization after hours, you will be able to access 211. If your need is more urgent, you can get care through Emergency Departments by dialing 911. To help direct our work with you, we will work together towards the goals described on your treatment plan.

The OHO Consumer Handbook I will receive will explain in Detail: **1**. How to Get Help/Report Abuse **2.** Consumer Rights and Responsibilities **3.** OPTIMUM HEALTH OUTCOMES, L.L.C Rights and Responsibilities **4.** Confidentiality and Release of or Request For Information **5.** Notice of Privacy Practices **6.** How to Plan and Receive Services **7.** Grievance Procedure 8. How Violations of Federal and State Laws should be reported to Appropriate Authorities of a provider or entity.

Insurances And Billing: If you have a health insurance policy with behavioral health coverage that is **not Florida Medicaid,** please check with your insurance company about whether services provided by Optimum Health Outcomes are covered by your policy. We will bill the insurance company; however clients are responsible for any amount that is not covered by their insurance policy. Statements with balance will be sent to Clients via email or mailing address on file.

Out of Pocket Fee: To meet the need for counseling and other behavior health services, discounted sessions are available for clients "paying out of pocket". OHO Personnel will discuss rates for out of packet care with you.

I consent to treatment and agree to abide by the above stated policies and agreements with Optimum Health Outcomes, LLC and it's affiliates. This consent is valid for until revoked or OHOLLC makes changes.

This consent will apply to multiple household members to receive services? ☐

IF ADDITIONAL PERSONS List Name(s)/ DOB/Relationship to the Consenting Person Here:

Name of Guardian or Family Consenting Person

Date:

Signature of Guardian/ Family Consenting Person:_

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OHO REFERRAL FORM

Date: _____

IF FAMILY ADDITIONAL INFORMATION FOR REFERRAL MUST BE ADDED TO THE FORM

REFERRAL INFORMATION.

Will There Be More than One Person From A Family Included on the Referral: ☐ Yes ☐ No

NUMBER OF FAMILY MEMBERS TO BE INCLUDED IN THE REFERRAL::_____ Do all FAMILY members live in the Same Home: ☐ Yes ☐ :No

FAMILY CONTACT NAME: _____ CLIENT/FAMILY EMAIL Address:_____

CLIENT'S/FAMILY INFORMATION

ALL INFORMATION LISTED DIRECTLY BELOW IS FOR INDIVIDUAL CLIENT / OR REFERRED FAMILY MEMBER #1. ☐

*Accepted Medicaid Providers (Sunshine, Humana, Aetna Better Health, Simply, Staywell/**CMS**, Coventry, Healthy Kids*

Client's Name (OR Name of First REFERRED Family Member): _____

BIRTH GENDER ☐ :Male ☐ :Female DOB :_____ Age: _____ IN DCF CARE: ☐ Race: _____GRADE: _____

School (or) Job: _____ BEST CONTACT PHONE #: _____

BEST TIME TO CONTACT?: _____ ALT CONTACT PHONE #: _____

CLIENT/FAMILY PRIMARY ADDRESS: _____ City:_____Zip Code:_____

NAME OF INSURANCE: _____ MEDICAID NUMBER(CLIENT/FAM #1:_____

IF MEDICAID NUMBER IS UNKNOW LIST DCF CASE NUMBER(dcf-access.dcf.state.fl.us): _____

PLEASE IDENTIFY BEHAVIOR SYMPTOMS exhibited by referral/ family member

Non-Compliance ☐ Physical Aggression ☐ SELF INJURY ☐ LYING ☐	☐Greif ☐HOMELESSNESS ☐ Tantrum BehavioR PROPERTY DESTRUCTION ☐	☐Appetite Changes ☐POOR SCHOOL GRADES ☐RUNAWAY BEHAVIOR	☐HOMICIDAL ☐ SUICIDAL ☐DELUSIONAL/HALLUCINATING ☐DISRUPTIVENESS
Verbal Aggression ☐ Stealing ☐ ☐INAPPROPRIATE SEXUAL BEHAVIOR	☐Anxious/ Anxiety ☐DEPRESSION ☐SLEEP DISTURBANCES	☐EATING DISORDER ☐SUBSTANCE ABUSE OTHER ☐:	ABUSER(SEXUALLY/PHYSICALLY, ETC) ☐ ABUSED(SEXUALLY/PHYSICALLY, ETC) ☐ OTHER ☐

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OHO REFERRAL FORM

PLEASE INDICATE SERVICES DESIRED:	
☐Targeted Case Management	☐Family Counseling (VIRTUAL/OFFICE)
☐Intensive Adult Targeted Case Management	☐ Individual Counseling (VIRTUAL/OFFICE)
☐Mentoring (AVAILABILITY*)	☐ Tutoring (AVAILABILITY*)
☐ Individual Counseling (VIRTUAL/OFFICE/SCHOOL)	☐ Group Counseling
Other:	

Referral Source:

Name: _____**Agency:** _____

Phone_____**Email**_____

ADDITIONAL FAMILY MEMBER FOR THE REFERRAL: EACH ADDITIONAL PERSON: NAME, DOB, MEDICAID NUMBER, ADDRESS IF DIFFERENT FROM ABOVE, ADDRESS, LIST CONTACT NUMBER FOR THE REFERRED CLIENT IF DIFFERENT FROM ABOVE, LIST OF SYMPTOMS. LIST AS MUCH INFORMATION AS NEEDED

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Consent to Receive Behavior Health Services

(1) I voluntarily hereby consent for Optimum Health Outcomes, L.L.C (OHOLLC) to provide Behavioral Health Services to Client/ Family Members as listed above

I Understand that OHOLLC is providing services via telehealth, I also consent to receive telehealth services. I authorize OHOLLC to release appropriate information concerning my care for billing purposes to any of the following: Social Security, HCPA or its intermediaries, Medicaid, Medicare, or any other insurance compensation carrier.

(2) I Understand Non-Voluntary Discharge from Treatment: A client may be terminated from the practice non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the Clinic Director or request to re-apply for services at a later date.

(3) I understand that it is mandatory to notify OHOLLC of any other party who may be responsible for paying for the client named above.

(4) I authorize OHOLLC and/or staff to release any information concerning my care, advice, or services needed or that have been provided to my insurance carrier and/or its agents to determine the benefits payable for related services.

(5) A copy of this authorization may be signed in lieu of the original.

(6) All communication via client and OHO becomes part of the clinical record, which is accessible to you upon request. This information will be kept confidential by OHO at all times unless:
You direct OHO to discuss with specific person(s) , OHO determines that you are a danger to yourself or others, or OHO is ordered by a court to disclose

(7) The rights, risks and benefits associated with the treatment have been explained to me. I understand that the services may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

_____	_____	_____
PRINT NAME OF CONSENTING PERSON	SIGNATURE OF CONSENTING PERSON	DATE

THE PERSON SIGNING THIS FORM IS THE (Please check the appropriate title):
☐ PATIENT ☐GUARDIAN ☐ LEGAL / FAMILY REPRESENTATIVE OTHER

By signing above you are acknowledging that you have read and understood this statement and/or that any questions you have about this statement have been answered to your satisfaction.

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Patient Record of Disclosures

In general, the HIPPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of the protected health information (PHI). The individual is also provided the right to request confidential communications or that all communications of PHI is made by alternative means.

-I prefer to be contacted by:

☐ Home phone ☐ Cell phone ☐ Work Phone ☐ Email

-Is this contact method safe to leave detailed information on? ☐ Yes ☐ No

*If no then please provide an alternate method of communicating:

-If the need arises, can we send information to the provided address? ☐Yes ☐No

*If no then please provide an alternative address: _____

You have the right to request restriction or limitation on the medical information we release about you to someone who is involved in your care/case or payment of your care.

**I DO NOT give permission to disclose my medical or financial information to the following

_____

Consenting Person Name: Date:

Consenting Person Signature: _____

Acknowledgement Form

Our Notice of Privacy Policies provides information about how we may use and release protected legal information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice you may obtain a revised copy by writing our practice and requesting it.

You have the right to request that we restrict how your protected health information is used or released for treatment, payment and healthcare operation. We are not required to agree to this restriction, but if we do we are bound by agreement.

By signing this form, you consent to our use and release of your protected health information for treatment, payment and healthcare operations as described in our Notice. You have the right to revile this consent, except where we have already made releases on your prior consent.

Authorized Person Name (Print): _____

Signature: _____ Date:

The person signing this Form is the ◯ Client ◯ Parent/Legal Guardian ◯ Family Representative

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Name of Client: Date of Birth:

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The OHO, Consumer Handbook Contains the Following Information.

- Definitions
- How to Help Yourself
- Consumer Rights and Responsibilities
- OPTIMUM HEALTH OUTCOMES, L.L.C Rights and Responsibilities
- Confidentiality and Release of or Request For Information
- Notice of Privacy Practices
- How to Plan and Receive Services
- OHO's Grievance Procedure
- Notice of Privacy Practices

I , _____ acknowledge that the OHO Consumer Handbook was provided to me. I also acknowledge that time was given to me to ask questions and I understand the answers that were given to me. I also understand that I may contact my assigned Staff Member or the Organization at 689 201 2702 if I have additional questions or concerns related to the Consumer Handbook

_____ _____

SIGNATURE OF CONSENTING PERSON DATE

The Person Signing This Form is the

CLIENT ◯ PARENT/GUARDIAN ◯

FAMILY REPRESENTATIVE ◯

☐

CONSENTING PERSON Refused to Sign.

Reason for Refusal to Sign: