Transformative Wellness, LLC

Who We Are

Transformative Wellness, LLC ("we", "us", "our", "Team") - located at 815 S. South St, Wilmington, OH, 45177 - is a private, for-profit system of care that provides accessible, affordable, quality behavioral health services to the residents of Clinton County and surrounding areas in Ohio. We are committed to offering comprehensive, balanced, and coordinated care based upon the wellness wheel. We advocate for the individual dignity of our clients and are committed to providing a safe and educational environment for our Team members, clients, and stakeholders.

What We Believe

Mission
- Wholistic care
- Wellness wheel
- Innovative ways
- Personal wellness

Vision
- Quality services
- Anticipate evolving needs

Diversity
- Value & appreciate
- Safe environment
- Recognize rights
- Respect & dignity
- Promote growth

Values
- **E**xcellence
- **T**eamwork
- **H**onesty
- **I**ntegrity
- **C**ompassion
- **A**uthenticity
- **L**eadership

What We Do

We provide outpatient behavioral health services to individual adults, couples, families, and children. We also offer group psychotherapy for a variety of issues.

- Screening and assessment
- Counseling for substance use disorders, mental health concerns, family dynamics
- Group (educational, therapeutic, correctional)
- Workshops for professional development
- Collaboration with stakeholders: family members and supportive others, courts, medical community, faith-based community

How We Do

Sessions are typically 45-60 minutes in length and are expected to begin and end on time. If you arrive late for a session, your end time will not be extended. In the event that your counselor is tardy, your session may be extended. The continuity of your care promotes faster healing and progress in the treatment process. So, it is beneficial for you to attend your scheduled sessions consistently. If you cannot attend a session, you agree to notify us at least 24 hours in advance when possible.

Cancellations We reserve the right to terminate your services when you have three (3) cancellations with less than 24-hour notice.

Late Arrivals We reserve the right to reschedule your appointment when you are (15) minutes or later. If you arrive past your appointment time, and within the (15) minute window, your session will not be extended.

Transfer or Termination We reserve the right to transfer and/or terminate services at any time for any reason considered therapeutically appropriate.

Unconfirmed Appointments We reserve the right to cancel appointments that are not confirmed via text or email when you opt-in for the reminder service.

Our Promise to You

The Team complies with all aspects of the *Americans with Disabilities Act (ADA)*. Our building is handicap accessible. We provide adaptive/technical equipment and assistance to all clients, either locally or through appropriate referral. We make every effort to identify clients with disabilities and their needs for reasonable accommodation. If you have a need for an accommodation of which we have not identified, we encourage you to discuss those needs with your primary counselor.

If you need assistance after hours because you feel unsafe or symptoms become severe, you are encouraged to do one of the following:

1. **County Crisis Hotline (877) 695-NEED**
2. **National Suicide Hotline (800) 273-TALK**
3. **Crisis Text Line text "CONNECT" to 741741**
4. **Visit nearest Emergency Room**
5. **Call 9-1-1**

Making a Complaint

A complaint can be made by the service user or community member with support if necessary. The complaint may relate to any aspect of the agency's programs and services. A service user or community member who believes they have experienced discrimination by any Team member contrary to the **Client Rights** can file a grievance with the Clinical Director.

Sharon Yockey, MA, LPCC-S
(855) 553-9355
sharon@transformative-wellness.com

If the service user or community member is not satisfied with the response received, the complainant may take the complaint to any of the following state agencies:

OH Mental Health Addiction Services
30 E. Broad St 36th FL
Columbus OH 43215-3430
TEL: (614) 466-2596
TTY: (614) 752-9696

OH Counselor, Social Worker, Marriage & Family Therapist Board
77 S. High St 24th Fl
Columbus OH 43215-6171
TEL: (614) 466-0912
FAX: (614) 725-7790

OH Chemical Dependency Professionals Board
77 S. High St, 16th FL
Columbus OH 43215
TEL: (614) 387-1110
FAX: (614) 387-1109

OH Disability Rights Law & Policy Center Inc
50 W. Broad St
Columbus OH 43215-5923
TEL: (614) 466-7264, (800) 282-9181
TTY: (614) 728-2553, (800) 858-354

Collecting & Storing Client Data

An electronic health record (EHR) record is maintained for each client. Your EHR will be maintained for 7 years post-discharge and destroyed per the Health Insurance Portability and Accountability Act (HIPAA).

1. All EHRs are stored in an off-site, HIPAA-compliant, password-secured location.
2. A "client record" will contain demographic, identifying, and financial data; verification of consent, identity, income, insurance; a biopsychosocial assessment; progress notes; treatment plans; level of care forms; testing instruments and results; collateral information; releases of information; and discharge summaries.
3. Clients may receive one copy of their record once they make this request in writing and complete and sign a Release of Information to release this private information to their custody. We reserve the right to charge for additional copies at $.20 per sheet.
4. Client information and/or records will not be released to third parties without an authorized Release of Information on file, unless responding to the law, regulations set forth herein, or in the case of emergency. At all times, client privacy will be maintained to the extent permitted by law; therefore, we will maintain the practice of only releasing what is ***minimally necessary***.

Health Alert

If you are a moderate to heavy consumer of drugs or alcohol, of if you have ever used any type of IV drugs in the past, you are at a higher risk for contracting communicable diseases such as sexually transmitted infections, tuberculosis, hepatitis B, hepatitis C and/or HIV/AIDS. We recommend you contact your personal physician or local county health department for a tuberculosis and/or HIV identification test. If you become aware you have a contagion (fever of 100 degrees or higher, scabies, etc), you must immediately contact us to reschedule your sessions accordingly. You must have a signed medical release permitting you to return to therapy. The local health unit is:

Clinton County Health Department
111 South Nelson Ave, Suite 1
Wilmington, OH 45177
Phone: (937) 382.3829
Fax: (937) 382.7027

Transformative Wellness, LLC

As a client of TRANSFORMATIVE WELLNESS, LLC, you have the right:

1. to be treated with consideration and respect for personal dignity, autonomy, and privacy
2. to receive services in the least restrictive, feasible environment
3. to be informed of one's own condition
4. to be informed of available program services
5. to give consent or to refuse any service, treatment, or therapy
6. to participate in the development, review and revision of one's individualized treatment plan and receive a copy
7. or freedom from unnecessary or excessive medication, unnecessary physical restraint or seclusion
8. to be informed and the right to refuse any unusual or hazardous treatment procedures
9. to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, or photographs
10. to consult with an independent treatment specialist or legal counsel at one's own expense
11. to confidentiality of communications and PHI within the limitations and requirements for disclosure of client information under state and federal laws and regulations
12. to know the names of the Team involved in your treatment
13. to be informed of the reason for denial of a service
14. not to be discriminated against for receiving services based on race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws
15. to know the cost of services
16. to be verbally informed of all client rights, and to receive a written copy upon request
17. to exercise one's rights without reprisal, except that no right extends so far as to supersede health and safety considerations
18. to file a grievance
19. to have oral and written instructions concerning the procedure for filing a grievance, and to assistance in filing a grievance if requested
20. to be informed of one's own condition
21. to consult with an independent treatment specialist or legal counsel at one's own expense

As a client of TRANSFORMATIVE WELLNESS, LLC, you have the responsibility:

1. to be honest about matters that relate to you as a client
2. to participate in the development of your service plan and treatment recommendations
3. to attempt to follow the directions and advice offered by the Team
4. to give 24-hour notice of any appointment cancellations
5. to report changes in your condition to those responsible for your care and welfare
6. to be considerate and respectful to the rights of other clients and Team
7. to honor the confidentiality and privacy of other clients
8. to dress appropriately for telehealth and in-office services.
9. to conduct yourself in an appropriate manner in the office and on telehealth.
10. to notify Team or the Clinical Director if you feel your rights are being violated

11. to assure that the financial obligations of your healthcare are fulfilled as promptly as possible
12. to follow our rules and regulations affecting your care and conduct
13. to inform us immediately if you require a Translator or other accommodations. These will be provided to you at no cost.
14. To notify your provider of any changes in medication and/or medical treatment including any new/emerging concerns, changes in type of medication/milligram/medication dosing. Please provide a copy of your medication to your provider for entry into your clinical record.
15. to remain discrete about taking any medication you may need to take while at our office.

Weapons, alcohol or drugs are **NEVER** permitted onto the property. Bringing any of these onto the premises will result in automatic termination of services, a report filed with the local police department, notification to your referral source, and/or banning from the property.

- **Weapons** includes guns, knives, pocket knives, box cutters, brass knuckles, picks, explosive devises, pepper spray, etc.
- **Alcohol** includes beer, wine, distilled liquors, mixed drinks, energy drinks containing alcohol, medication with alcohol as an ingredient, rubbing alcohol or any other form.
- **Drugs** include prescriptions that are not prescribed, marijuana (in any form), heroin, pills, methamphetamine, “street-market” drugs (i.e., khat, bath salts, K-2), hallucinogens, and any other drug or substance used to alter a mind-body experience. It also includes paraphernalia such as needles, rigs, pipes, etc. used for ingesting substances for a change in the mind-body experience.

Professional Disclosure Statement

All Team members adhere to the Code of Ethics of the profession to which they belong. These are available upon request. Dual relationships and sexual intimacy between a counselor and a client are never appropriate.

Client Caregiver Relationship

Professional Credentials

Transformative Wellness, LLC

Effective Date: April 14, 2003; updated for HIPAA Security April 20, 2005 and Final Rule 2013

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

Our Responsibilities

TRANSFORMATIVE WELLNESS, LLC ("we", "us", "our", "Team") is committed to protecting your personal health information (PHI). This notice applies to all of the records of your care generated by this mental health care practice. We are required by law to:

- Make sure that Protected Health Information ("PHI") that identifies you is kept private.
- Give you this notice of our legal responsibilities and privacy practices.
- Follow the terms of the notice that is currently in effect.
- We may change the terms of this Notice. The new Notice will be available upon request, in the office, and on our website.

Uses & Disclosures Not Requiring Authorization

Subject to certain limitations in the law, we may use and disclose your PHI without your authorization for the following reasons:

- When disclosure is required by state or federal law
- Public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety
- Health oversight activities, including audits and investigations
- Judicial and administrative proceedings
- Law enforcement purposes
- Research purposes
- Workers' compensation purposes in compliance with workers' compensation laws
- Specialized government functions
- Appointment reminders and health-related benefits or services
- Other licensed health care professionals involved in your Individualized Plan of Care
- To obtain payment for the treatment you receive
- Healthcare operations, including accountant, attorney, or federal/state officials for audits.

Uses & Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations with your written authorization. We are required by law to obtain an authorization before releasing your psychotherapy notes, except under certain limited circumstances. These notes are given a greater degree of protection than other PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Uses & Disclosures Requiring Opportunity to Object

We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

Communications

The Team will not guarantee the confidentiality of any form of electronic communication (i.e., text messages, emails, and video messaging). Any email sent from you, the client, to your counselor via computer in a work-place environment is legally accessible by an employer. Your counselor is ethically and legally obligated to maintain records of each time you meet, talk on the phone, and/or correspond via electronic communication.

You may decline to communicate with us via text messaging, email, or phone. To maintain the safe boundaries of your therapeutic relationship, no member of the Team will accept friend or contact requests from you on any social networking media.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we make about access to your records, you may:

- Contact the Clinical Director: **Sharon Yockey, MA, LPCC-S, (885) 553-9355**
- Submit a complaint through Ohio Mental Health and Addictions Services (OMHAS).
- Submit a complaint to the U.S. Department of Health and Human Services

Acknowledgement

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document. you acknowledge that you understand and have received a copy of the HIPAA Notice of Privacy Practices.

Client | Caregiver | Relationship

Professional | Credentials

Payments

- We are supported by self-pay clients (Cash, Check, Money Order, Square, Apple Pay, Android Pay, Paypal, Visa, Mastercard, Discover, American Express) and insurance reimbursement (accepted insurances on website).
- Payments are due on the day of services rendered.
- Outstanding balances must be paid prior to scheduling a future appointment.
- We do not provide a sliding fee scale. Instead, we provide limited pro gratis services for indigent individuals. This option may be available at the time of intake. Please discuss further with your counselor.
- If previous arrangements are not made with Monica Hill, Chief Financial Officer, any outstanding balance older than 90 days will be forwarded to a collection agency. We reserve the right to charge an additional 25% of your outstanding balance and all costs and expenses – including legal fees – we incur in such collection efforts.
- A $30 fee will be charged for checks returned due to insufficient funds.
- Neither gifts nor bartering for services is appropriate.

Fee Schedule

Diagnostic Evaluation		$130
Individual Therapy (30m)		$60
Individual Therapy (45m)		$90
Individual Therapy (60m)		$120
Extended Therapy (initial 60m)		$120
Extended Therapy (ea add'l 30m)		$60
Interactive Complexity		$14
Family Therapy w/out Client		$105
Family Therapy w/ Client		$110
Group Therapy		$25
Multiple Family Group Therapy		$30
Crisis Intervention (initial 60m)		$130
Crisis Intervention (ea add'l 30m)		$65

Specialized Services/Evaluations/Assessments - fees vary

Insurance

When paying with insurance, you are giving authorization to us to provide your insurance company(ies) with a clinical diagnosis and/or additional clinical information. If we do not participate in your insurance, or your insurance is discontinued at any time, payment in full is

expected at the time of services rendered. We will supply you with a superbill that may submitted to your insurance for reimbursement.

Co-payments, Co-insurances

Co-payments and co-insurances are due at the time of each scheduled appointment. You will not be permitted to schedule a future appointment until any outstanding balance is paid in full.

Your Responsibility

You are responsible for keeping us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the services rendered and for submitting the charges to the correct plan for reimbursement. You are responsible to understand your benefit plan coverage for all services rendered through us. It is your responsibility to keep us updated If your bill for services rendered is not paid promptly.

Acknowledgement

I have read and fully understand the above provisions. I give permission to and request that *Transformative Wellness, LLC* bill my insurance, Medicaid, or any third-party payer for services rendered to me or to a member of my family for whom I am responsible. I clearly understand that it is my responsibility to make sure that the bill is paid in a timely manner. If, for any reason, any portion or the entire bill is not paid by insurance, Medicaid, or any third-party payer, I agree to make arrangements for prompt payment.

Client | Caregiver | Relationship

Professional | Credentials

Transformative Wellness, LLC

I acknowledge that I have read, understand, and agree to the terms and conditions contained in this client handbook. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving treatment and services for myself/child, and understand that I may discontinue services at any time.

CLIENT	CLIENT'S CAREGIVER
☐ I give consent to treatment.	☐ I give consent to treatment.
☐ I ***DO NOT*** give consent to treatment.	☐ I ***DO NOT*** give consent to treatment.

Client

Caregiver

Relationship

Professional

Credentials