Behavioral Healthcare Partners of Central Ohio, Inc.
Notice of Enrollment
GOSH Billing System

Client Name:	Date of Birth:

I authorize Behavioral Healthcare Partners of Central Ohio, Inc. (BHP) to disclose to Mental Health and Recovery for Licking and Knox Counties (MHR), from whom I am seeking funding for services, the Ohio Department of Mental Health and Addiction Services and/or Job and Family Services ("Departments"), the information necessary to accomplish the following purposes:

- To enroll me in the GOSH System which is the shared computer payment system used by MHR and the Departments.
- To determine my eligibility for publicly-funded services.
- To pay claims for services I receive.
- To report information required by MHR and/or the Departments regarding characteristics of the individuals seeking services and the services provided. I understand that MHR and the Departments use the information in aggregate form for service planning and evaluation purposes.
- To report information, as required by Ohio law, about reportable incidents that may occur while I am receiving services to MHR and the Department(s).

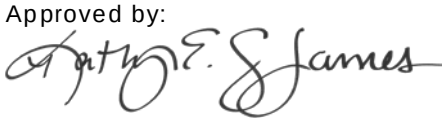
In signing this authorization for disclosure, I understand the following:

- I must authorize disclosure of information necessary for payment purposes in order to receive treatment services. My treatment or payment for my services cannot be conditioned upon my giving authorization for any purpose other than payment.
- I may revoke this authorization at any time, except to the extent action has been taken in reliance on it. If not previously revoked, this authorization will expire at the time my treatment ends.
- The information disclosed is protected by law and may not be disclosed further without my written authorization or as otherwise permitted by law; however, I understand that BHP cannot control the use of this information once it has been disclosed.
- Information necessary to obtain payment for services rendered will be submitted to MHR, Behavioral Health Generations, and GOSH. Billing information will be kept for up to seven (7) years after services are terminated and only demographic information will be kept after that time.

I have read and understand the information regarding the notice of enrollment and authorize such enrollment for the purposes outlined above.

Client Signature:	Date:
Authorized Representative Signature:	Date:
Witness Signature:	Date:

Origination: 07/10
Effective: 08/22/18
Approved by:



Kathryn E. St. James, President & CEO
Behavioral Healthcare Partners of Central Ohio, Inc.