Patient Information and Professional Service Agreement

Welcome to Select Psychiatry . This document contains important information about our professional services and business policies. Please review it carefully and feel free to ask questions. Once all your questions have been answered, please sign at the bottom to indicate that you have read this contract and agree to its terms.

Services Provided

We provide psychiatric medication management and psychotherapy.

Successful psychiatric treatment depends upon close collaboration and open communication between psychiatrist and patient. While we will make every effort to help you reach your treatment goals, we cannot contract for a guaranteed result.

Length and Frequency of Meetings

Treatment begins with an initial consultation approximately 45 to 60 minutes in length, depending on complexity. During this meeting, we will explore your reasons for seeking treatment, review your psychiatric, social, and medical history, and begin to establish goals for our work together.

After our initial meeting, we may embark on a period of extended evaluation, generally two to four sessions in length, although this varies. During this time, we will continue to review your history, examine our unfolding therapeutic relationship, and determine how we can help you reach your treatment goals.

Mental health treatment involves regularly scheduled face-to-face meetings and via telepsychiatry and are 15 minutes to 30 minutes long.

Fee Policies

Please refer to the current fee schedule for details of pricing. Fee schedule is $300 for an initial evaluation and $ 250 for a follow up. A Good Faith Estimate, as required by the No Surprises Act for out-of-network services, is included in this packet.

Please note that as part of the initial evaluation, calls to obtain collateral information and review of prior records are included at no extra charge unless they extend beyond an hour of additional time. Please note that we do not charge for brief phone calls under 10 minutes, brief text exchanges, medication refills or brief responses to emails. This cost is factored into our standard hourly rates. Extensive text or email exchanges taking beyond 10 minutes/day to address will be subject to being charged at the clinician's standard fees, prorated to 15-minute intervals.

Substitution of a phone or video-chat visit for an in-person visit is not always reimbursed by insurance companies for out-of-network clinicians. In the event of a planned phone or video

session visit in lieu of an in-person appointment, the standard in-person appointment rates will apply.

If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if called to testify by another party. Because of the difficulty of legal involvement, we charge per hour for preparation and attendance at any legal proceeding. The exact fee will be set at the time our involvement is requested. Please note that unless explicitly agreed upon at the start of our work together, our role is first and foremost as your clinicians and not as expert witnesses that render opinions for the courts. We cannot serve as both an impartial evaluator for the court and as your treaters. At times, we could be called to testify as a “fact witness” where we do not render opinions regarding the legal matter but could be called to state objective facts about our work together.

You may request a Good Faith Estimate of the cost of your care be provided in writing at any time. We reserve the right to increase fees in the future.

Payment

We accept all major credit cards, checks, zelleand cash. Payment is preferred at the time of service and will be considered past due after [X] business days. Please note, for initial consultations at the practice we request a 10% deposit at the time of booking. For initial consultations canceled with more than 48 hours notice that deposit amount will be refunded. We request that a credit card be placed on file and work with a credit card processor (Stripe or Square) that securely stores the information according to industry standards. Please note that once entered, we do not have access to the actual number other than the last four digits. We will charge the payment method on file after sessions according to our fee policies. Individuals who cancel or reschedule initial consultations may be re-booked at the discretion of the clinician. Typically, no more than one re-scheduling in advance is permitted for an initial consultation. Patients or the responsible financial party are responsible for any returned check fees.

As the subject of delinquent bills can be the source of difficulty in a psychotherapeutic relationship, if arrangements for payment have not been agreed upon, we have the option of terminating treatment and/ or using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim.

We understand that credit card fraud is common and from time to time we learn a charge has been disputed by the financially responsible party. We also recognize that billing errors can occur on our end as well. We ask that any disputes or concerns about billing be handled first by contacting us directly rather than disputing a charge with the credit card company. Disputing charges for services agreed upon and rendered due to not being satisfied with the results is not an effective way to address concerns and can disrupt treatment efforts and the therapeutic alliance.

Cancellations

If you need to cancel an appointment for any reason, please give at least 48 hours notice. Otherwise, your cancellation may include a cancellation fee based on our three-strike policy. *First late cancels/no shows will be waived as a courtesy. Second late*

cancels/no shows will be half of the cancellation fee. Third and following late cancels/no shows will be the full cancellation fee. We are defining a "cancellation fee" as the full cost of the visit if it is private pay, or the amount we would have received from insurance + copay for insurance based visits. Cancellations towards any appointment type will be applied towards the three-strikes policy. This three-strike policy also resets each year in January.

Please initial here that you have read and agree to this policy: _____

Please be aware that insurance carriers will not reimburse you for cancellation charges. We reserve the right to waive the cancellation fee under certain unforeseen and unavoidable circumstances (for example, state of emergency / severe weather / natural disaster / you or a family member are hospitalized or being evaluated in an emergency room or urgent care setting). Regular attendance at our appointments is a key component of successful treatment and if problems arise with attendance, it is important that we work together to develop a feasible treatment plan. We in turn will make every effort to start sessions on time and will only cancel in the event of a personal or clinical emergency with as much notice as is possible.

Please note that you may receive automated confirmations and reminders of appointments. These notifications are a courtesy and technical glitches sometimes occur so in the event a reminder is not received, you are still responsible for keeping track of when your appointments are. Please feel free to contact us if you are unsure. Your signature of this document indicates you understand and agree to receive these communications.

Vacation and Time Away

It is our practice to take vacation and attend professional conferences or engage in other work travel. Whenever possible, we will give you advance notice regarding absences. We will arrange for coverage by another qualified clinician for urgent and emergent situations while away.

Insurance

At this time, we are taking medicare and self pay. Therefore, unless otherwise informed, you will be personally responsible for the full cost of your treatment.

Communication Outside Scheduled Appointments

Please feel free to contact your clinician(s) and administrative staff via phone call or via the portal. Calls and portal are generally returned within 24 hours on weekdays, usually within the same business day. In the event of a life-threatening psychiatric or medical emergency, please go directly to the nearest emergency room or call 9-1-1 rather than waiting for a call back. Please ask to have your clinician called once you are safely in the emergency room while safely en route. Do not call the administrative assistant in the event of emergency. Note that call and messaging via portal are not heard until the next business day.

Social Media Policy

Please note that we do not accept “friend” requests or follow patients or their family members on our personal social media accounts. If we were already following each other on social channels prior to meeting, that is an exception. We may maintain professional social media accounts and anyone in the general public can follow these accounts should they choose to do so. Note that by “liking” or following a professional social media account of the practice or its clinicians, others may be able to see that you follow it. Please do not contact your clinician(s) via their professional social media accounts as these are not secure means of communication and may not be responded to in a timely fashion. Reserve contact to the HIPAA compliant methods outlined above. Clinicians may, especially in the case of emergency, review any public social media content that you are associated with if it could be relevant to treatment and your well-being. However, in non-emergent situations, we will discuss social media content together should you choose to share that dimension of your life in treatment. You may find our practice or providers listed on business review sites such as Google Reviews, Yelp or Healthgrades. Note that we will not respond to reviews left on these sites about your care specifically due to confidentiality. If you have feedback about the care you have received, we encourage you to address that directly with us rather than on these. If you would like to write a review, regardless of whether it is positive or negative, we encourage you to create a pseudonym and not include any personally identifiable details in order to preserve your confidentiality. We are committed to ensuring that our patients receive appropriate medical care.

Communication with Other Providers and External Entities

Physical and mental health are inextricably linked. Excellent mental health treatment often depends upon a team approach that involves frequent communication among all mental health and general medical providers as well as other stakeholders. In order to provide high-quality care, we will frequently need to maintain contact with your medical (PCP and relevant specialists) and mental health (prescriber or therapist) providers. We will provide you with HIPAA-compliant Release of Information forms by which you can share with us your other providers’ or stakeholders' contact information and give us permission to exchange information with them. Within our practice, we work collaboratively and meet regularly to discuss cases so by joining the practice, you agree to us communicating with other clinicians within our practice unless you specifically request that we do not, such as if you personally know one of our clinicians.

In the course of doing business, we may need to share your personal information with outside businesses such as insurance agencies, credit card processors and our electronic medical record vendor. Please note that when relevant we have Business Associate Agreements on file with these companies where they agree to uphold the standards of HIPAA to maintain your privacy. We only share the minimal information necessary to conduct business.

Confidentiality

Confidence in patient/doctor confidentiality is an essential component of mental health treatment. Information that you share with our practice will be kept strictly confidential and will not be disclosed without your consent. A written release of information is usually required for the transfer of information, except as discussed below.

To provide optimal care, we may need to discuss your treatment with a colleague. In this case, we will take pains to conceal or disguise identifying information, including using a pseudonym or first name only. In addition, we may receive peer supervision from other clinicians within our practice but no one from our practice will access your chart unless involved in your clinical care.

There are some exceptions where we may share information without your authorized release. For example, we are required to report abusive treatment and/ or neglect of a child, elder, or disabled person to the proper authorities. We must report the threat of serious bodily harm to oneself or others and take appropriate steps to prevent it. We may seek a patient's hospitalization in order to protect the individual. If warranted, we may notify the potential victim of a threat, as well as the potential victim's family members or police. In some legal proceedings, upon the order of the court, we may be obligated to testify or render records of your treatment. If a patient or a member of their family brings legal action against any of us and/or the practice, information may be disclosed if necessary and relevant to the case. For patients under the protection of a legal guardian, we will need to report general feedback on treatment progress to the guardian. In the event of non-payment of our treatment fees, we may need to disclose information to a collection service or small claims court. We also from time to time may share de-identified and anonymized data for the purposes of conducting research using real-world evidence and adhere to the highest standards for the de-identification of PHI.

Please note that loved ones or other concerned parties may at any time disclose information with clinicians at our practice. We are not able to confirm that a patient is under our care or provide other information without a signed release, except in case of emergency as noted above, but cannot reject information that is provided to us from people who know a patient. It is our practice to notify you if we do receive information like this from people in your life.

Please see our detailed Notice of Privacy Practices for further information.

Freedom to Withdraw

We each have the right to end treatment at any time. If you wish, at the time of termination, we will give you the names of other qualified mental health professionals or programs. If our practice or a clinician within our practice has made the decision to end treatment, we will generally provide a 30 day window of time to continue to provide coverage while new arrangements are arranged or until you meet with a new clinician, whichever comes first. Please note that if you have not made an appointment with your clinician after 1 year from the last visit we will assume you no longer wish to be seen by the practice unless you have contacted us to make other arrangements. We will consider you discharged from the practice at that time. Most patients are seen at a minimum of every 3 months and if you have not been seen in over a year, we would likely need to repeat much of the intake process if you choose to re-enter the practice and this is at our discretion.

Informed Consent

I have read and understood the preceding statements. I have had an opportunity to ask questions about them, and I agree to enter treatment withSelect psychiatry.

Signature:_____

Printed Name of Person signing form and relationship to the patient if signing on their behalf: _____

Date:_____

[INSERT CLINIC NAME]
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ("PHI") MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical health or condition, treatment, or payment for health care services and includes information that we have created or received regarding your health or payment for your health. It also includes both your medical records and personal information such as your name, social security number, address, and phone number.
I. OUR PLEDGE REGARDING HEALTH INFORMATION: We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. Under federal law, we are required to:

- Protect the privacy of your PHI. All of our employees and clinicians are required to maintain the confidentiality of PHI and receive appropriate privacy training
- Provide you with this Notice of Privacy Practices explaining our duties and practices regarding your PHI
- Follow the practices and procedures set forth in the Notice
- We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

II. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. We may also disclose your protected health information for the treatment activities

of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word “treatment” includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. We do sometimes keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For our use in treating you. b. For our use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy. c. For our use in defending ourselves in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate our compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes. g. Required by a coroner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a mental health practice, we will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a mental health practice, we will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, we can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For 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.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although our preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy/treatment versus those who received another form of therapy/treatment for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although our preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment with us. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. 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.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and we may say "no" if we believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How We Send PHI to You. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost-based fee for doing so as permitted by state law.
5. The Right to Get a List of the Disclosures We Have Made. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or healthcare operations, or for which you provided us with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right

to request that we correct the existing information or add the missing information. We may say “no” to your request, but we will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE: [INSERT DATE]

For any questions or concerns:

Select psychiatry

5130 Linton Blvd

Suite C-2

Delray Beach , Fl 33484

Acknowledgement of Receipt of Privacy Notice

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 checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature:_____

Printed Name of Person signing form and relationship to patient if signing on their behalf:_____

TELEHEALTH INFORMED CONSENT

Telehealth is the delivery of psychiatric and other mental health and medical services using interactive audio and visual electronic systems where the clinician and the patient are not in the same physical location. [INSERT CLINIC NAME] allows its clinicians to perform telehealth when clinically appropriate using HIPAA-compliant platforms including Zoom. The interactive electronic systems used by these platforms incorporate network and software security protocols to protect the confidentiality of patient information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential Telepsychiatry Benefits:

- Increased accessibility to care

-Patient convenience

-Obtaining expertise of a distant clinician

Potential Telepsychiatry Risks:

-Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision-making by my clinician.

-Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment.

-Security protocols can fail, causing a breach of privacy of my confidential medical information.

-In rare cases, a lack of access to all the information that might be available in a face-to-face visit, but not in a telehealth session, could result in the omission of care involving other health problems or possible adverse drug interactions.

If I decide that the benefits outweigh the risks, I may request telehealth sessions when I schedule follow-up appointments. If my clinician agrees, I will be scheduled for a telehealth session, and I will be sent an internet link with instructions to log into the “waiting room” immediately prior to my scheduled appointment.

My Rights:

(1) I understand that all laws protecting the privacy and confidentiality of medical information also apply to telehealth.

(2) I understand that all the state rules and regulations which apply to in-person sessions also apply to telehealth sessions

(3) I understand that my clinician has the right to withhold or withdraw their consent for the use of telehealth at any time during the course of my care.

(4) I understand that I have the right to withhold or withdraw my consent for the use of telehealth at any time during the course of my care, and withdrawal of my consent will not affect any future care or treatment from my clinician unless it becomes logistically impossible to continue care. Referrals will be made if that is the case.

My Responsibilities:

(1) I will inform my psychiatrist as soon as my session begins of my physical location and will not unexpectedly join from states where my clinician is not licensed. I understand the clinician may need to terminate the session should I join from a location where they are not licensed. Exceptions are made in the case of emergency/crisis or sporadic visits while traveling that are clinically necessary for appropriate continuity of care. I will also join from a safe and private location and not while driving or operating heavy machinery.

(2) I will ensure the proper configuration and functioning of all my electronic equipment prior to my session because the computer, tablet, or mobile telephone I use must have a working camera and audio input so that my clinician can see and hear me in real time.

(3) I will not record any telepsychiatry sessions without written consent from [INSERT CLINIC NAME], and I understand that my clinician will not record any of our telehealth sessions without my written consent.

(4) I will inform my clinician as soon as my session begins if any other person can hear or see any part of our session.

(5) If I lose my connection during a session, I will immediately attempt to log back into the Zoom "waiting room." (6) If the audio I am receiving during a telehealth session is not complete and clear, I will attempt to let my clinician know or contact [INSERT CLINIC NAME], to schedule a new appointment.

Signature:_____
Printed Name of Person signing form and relationship to patient if signing on their behalf: _____

[INSERT CLINIC NAME],**. FEE AGREEMENT and GOOD FAITH ESTIMATE**

Patient Name: _____

Date of Birth: _____

Primary Diagnosis: (may state TBD pending evaluation for mental health if unknown):

_____

Date of Good Faith Estimate: _____

No Surprises Act

In compliance with the No Surprises Act that went into effect January 1, 2022, all healthcare providers including psychiatrists and therapists are required to notify patients of their federal rights and protections against “surprise billing.” The purpose of the Act and of this document is to protect you from unexpected medical bills.

This Act requires that we notify you of your federally protected rights to receive a notification *when services are rendered by an out-of-network psychiatrist or therapist (as we often are), if you are uninsured, or if you elect not to use your insurance*.

In case any of these situations apply to you, we are required to provide you with a “Good Faith Estimate” of the cost of services to you. Doing so is particularly challenging in mental health care because it is difficult to predict the length of treatment and because patients have a right to

decide how long they want to participate. Therefore, we describe below the fees that typically apply for the types of services we offer, including for your condition. Going forward, we can collaborate on a regular basis to determine how many sessions you may need.

As per our terms and our patient/provider agreement, all patients agree to pay the full rate unless otherwise negotiated before treatment begins or if in-network in which case they agree to pay their co-pay or co-insurance amounts and meet any necessary deductibles. If no payment is presented at the time of treatment, payment will be billed to the credit card we have on file. After the initial consultation, regular follow-ups are scheduled depending on clinical needs. If you are seeing one of our psychiatrists, then depending on your treatment plan and clinical discretion, the frequency of medication management appointments may range. Note that these rates will remain in effect for at least a year from the start date of treatment and in the event of a fee increase after that time, a new Fee Agreement will be presented.

[Select Psychiatry S Corp

Tax ID:

[INSERT CLINIC ADDRESS]

[INSERT CLINICIAN NAME] NPI: 1336263169

Rates:

$300 per hour for the initial consultation (usually 1hours), 10% due at time of booking

$250 / 30 Minute follow-up/ Medication Consultation

Expert consultation, including forensic or legal document review, and preparation of significant documentation is billed at $X/hour.

Appearances In court, depositions, and scheduled time addressing legal matters out of the office: $X/hr

- These fees apply to all American Psychiatric Association DSM-5 diagnoses and corresponding ICD-10 codes.
- I use diagnostic codes that are clinically accurate, but these do not guarantee reimbursement.
- Most often therapy is done once or twice weekly, but sometimes more or less often.
- Most often therapy continues for six months, one year, or several years, but short-term, brief therapy for intercurrent issues is also common. As noted above, because of this variability, please ask me about what can be expected in your case.
- Most often medication management is done every one to three months, but sometimes more often at the beginning of treatment and during periods of acuity, and sometimes less often.
- Most often medication management continues for several years or even longer; because of this variability, please ask me what can be expected in your case.
- It is your right to determine your goals for treatment and how long you want to remain in therapy.

Required Disclaimers:

- Should you have additional questions about your rights under this act, you can contact any of the following: The U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-MEDICARE (1-800-633-4227) or visit <https.//www.cms.gov/nosurprises> for more information about your rights under federal law. The Illinois Department of Insurance, Office of Consumer Health Insurance at (877) 527-9431.
- If you are billed for more than this Good Faith Estimate you have the right to dispute the bill. You may start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 days (about 4 months) of the date on the original bill.
- There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the healthcare provider, you will have to pay the higher amount**.**

If you have any questions related to billing, please contact us via the Osmind messaging system or speak to your clinician.

By signing this form, you agree to pay the full fee at the time of your treatment, unless otherwise arranged or if your clinician is in-network with your insurance. If in-network any co-pays or co-insurance are due at time of service.

It is a federal requirement that each patient sign this form annually to begin/continue treatment.

Signature:_____
Printed Name of Person signing form and relationship to patient if signing on their behalf: _____

Date:_____

Clinician Signature: _____

Clinician Printed Name: _____

Date:_____

Authorization to Disclose Protected Health Information

I _____ authorize [INSERT CLINIC NAME] to ___Obtain From and/or ___Release to **Person or Facility and Relationship to Patient (not patient's name unless releasing to self)** _____

Email (if known):_____ Phone (if known): _____ Fax (if known): _____ Time Frame *(release does not expire unless revoked or specified)* : _____

I hereby acknowledge that I fully understand the above statements as they apply to me and that my records cannot be disclosed without my written consent except as otherwise specifically provided by law. I understand that by law, I need not consent to the release of this information, but I choose to do so voluntarily.

Please release the following: ___Entire Record ___Progress Notes ___Treatment Plans ___Physical Exam ___Notice of Admission ___ Lab Reports ___Med Notes ___Summary ___Consults ___Psychological Tests ___Other, please specify:_____

This information is needed for: ___Ongoing Treatment ___Aftercare ___Referral

___Other, please specify: _____

Limitations on disclosure (if any):_____

The information to be disclosed may include confidential information as initialed below:
_____Psychiatric Evaluation/Treatment _____HIV Test Results _____Venereal Disease/STI/STD _____Alcohol/Drug Use (past or present)*

*NOTE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I further release [INSERT CLINIC LLC] from all legal responsibility or liability that may arise from this disclosure, and I understand that I may revoke my consent at any time, unless action on this release has already begun in good faith.

Signature:_____
Printed Name of Person signing form and relationship to patient if signing on their behalf: _____

Date:_____