



INFORMED CONSENT FOR THERAPEUTIC SERVICES

Welcome to our practice. This document describes our billing procedures, cancellation policy, privacy practices, and our mental health treatment services. Please read this document carefully and sign the last page to indicate your agreement with these terms of service. If you have questions, please speak with your provider.

Our Services

New Story Behavioral Health provides administrative and management services to independent, professional mental healthcare providers. As an independent provider, your provider is solely responsible for all matters concerning your clinical care and all questions about your care should be addressed to your provider. Our practice offers a range of services including psychiatric evaluations, psychotherapy (individuals, couples, families, and groups), and medical management of psychotropic medication. The range of ages treated may vary among our providers.

Therapeutic Outcomes

The success of your treatment depends on many factors and cannot be guaranteed. You will increase your chance of achieving your therapeutic goals if you are actively engaged in therapy, offer feedback to your provider about your progress, and integrate the insights you gain from your treatment into your daily life. If your provider determines that you would benefit from additional or alternative treatment from another provider, he or she will provide you with appropriate referrals and/or resources.

Scheduling and Availability

In order to provide you with the best possible care, it is common practice to schedule a regular day and time for ongoing appointments. The length of your sessions depends on the type of service provided. Providers in our practice determine their own schedules and may have limited availability. Limited phone contact is a part of ongoing treatment and generally is not billed unless the call exceeds 15 minutes in length. This charge is at the discretion of your provider.

Cancellation Policy

You are expected to maintain scheduled appointments. If you cancel or miss an appointment with less than 24 hours-notice, your credit card on file will be charged the full fee for the session. If we do not have your credit card on file, we will bill you the full fee for the session. Participants in group therapy are not refunded for any missed group sessions. Please see the "Informed Consent for Group Therapy" form for more information. Efforts will always be made to notify you directly if your provider needs to cancel an appointment due to a medical emergency. Please provide a phone number that includes a voice mailbox where your provider may leave a message for you.

Termination of Services

If you wish to terminate services, please discuss your decision with your provider. A closing session allows you to reflect on your progress and receive valuable feedback about your work in therapy. If you are not able to discuss your decision to terminate in person, please provide notice to your provider in writing or by phone. There are circumstances in which your provider reserves the right to terminate your treatment. Those circumstances may include, but are not limited to, your failure to follow through on recommended treatment, your failure to reschedule a missed appointment within a reasonable amount of time, or your provider's determination that you would benefit from a form of treatment not provided by your provider. Termination from services with a particular provider within our practice does not necessarily impact other services you may receive in our practice (groups, psychiatric care, etc.).

Cost of Services

Please note that by receiving services in our practice you are agreeing to pay for services. You will be expected to pay for services at the time of each session. Payment is the responsibility of the patient or the legal guardian of minor patients. In the case of shared custody of a minor, the parent who initiates treatment is responsible for payment. Please discuss any questions or concerns about payment with your provider. You may be charged for additional services such as report-writing, letter-writing, providing copies of documents, consultation with other providers, involvement in legal proceedings, and providing prescriptions outside of your regular office visits.

If you participate in group therapy, you will be billed automatically for services. Please see the "Informed Consent for Group Services" form for more information.

If you fail to pay an outstanding balance for more than 60 days and you have not made arrangements for payment with your provider, our practice has the option of using legal means to secure payment. Our billing service will make several attempts to reach you by phone and/or in writing. If these attempts are unsuccessful, we may utilize a collections agency to secure payment. In most collection situations, the only information this practice will release regarding a patient's treatment is legal name, the nature of services provided, and the amount due. If we must submit your outstanding balance to collections, you agree to reimburse our practice any fees charged by our collection agency and any necessary legal expenses.

Insurance Reimbursement

We are out-of-network providers for most health insurance plans. We will not file any insurance claims on your behalf. We will provide you with a "superbill" at the end of each month that you may use to file for out-of-network reimbursement. You should contact your health insurance provider to determine your rate of reimbursement, if any. In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. By signing below, you acknowledge responsibility for full payment of fees regardless of the amount covered by your insurance company.



INFORMED CONSENT FOR THERAPEUTIC SERVICES

Emergencies

If you believe you are at risk of harming yourself or someone else, please call 911 or go to your nearest hospital emergency department. You might also consider going to a hospital if you are not in danger but are experiencing extreme mental distress. Please also contact your provider to inform him or her of your condition.

Urgent Matters

If you have an urgent matter and need to get in touch with our practice after hours, please call our main number and follow the instructions to leave a message with our answering service. Please note that your provider is under no obligation to provide 24/7 availability. Your provider will do his or her best to return urgent calls within 24 hours.

Notice Of Privacy Practices & Confidentiality

The law protects the privacy of most information shared between a patient and a provider. In most situations, your provider can only release information about your treatment to others if you sign a written Authorization to Release Information (Release) that meets certain legal requirements imposed by the Health Insurance Portability and Accountability Act (HIPAA). You may revoke a Release in writing at any time. There are other situations that do not require a written Release and that only require written advance consent. Your signature on this form provides advance consent for the following:

- As your provider practices with other professionals within our practice, protected information may be shared for treatment and administrative purposes, such as case consultation, billing, scheduling, and quality assurance. All providers within our practice are legally bound by HIPAA.
- Your provider may, at times, find it helpful to consult health and mental health professionals from outside of this practice about your case. During consultation, your provider will make every effort to avoid revealing identifying information about you. These professionals are also legally bound by HIPAA.
- Our practice contracts with a medical billing service and collections agency. As required by HIPAA, we have a formal business associate contract with this agency in which they promise to maintain the confidentiality of patient data except as specifically allowed in the contract or otherwise required by law.
- If you choose to seek reimbursement for services, you should be aware that your contract with your health insurance provider requires our practice to provide information about your services. In some cases, your health insurance provider may share your information with a national medical information databank. By signing this form, you agree that our practice can provide requested information to your health insurance provider if you choose to seek reimbursement for services.

There are some situations when your provider is permitted or required by law to disclose information without your consent or authorization. These situations include:

- If you are involved in a court proceeding, your provider may be served a subpoena for your health record. If this occurs, your information may be released in a sealed envelope to the clerk of the court issuing the subpoena. If you are involved in or contemplating litigation, you should consult with your attorney to determine the likelihood that a court would seek your health record.
- If a government agency requests information for health oversight activities, your provider may be required to provide your health information.
- If you file a complaint or lawsuit against this practice or any provider within the practice, we may disclose your health information on behalf of our defense.

There are some situations in which your provider is legally obligated to take actions to protect yourself or others from harm. If this occurs, your provider may disclose your health information. These situations are unusual in our practice but may include:

- If your provider has reason to suspect that a child is abused, neglected, or exploited, the law requires that your provider make a report to the Department of Social Services. Once this report is filed, your provider may be required to provide additional information.
- If your provider has reason to suspect that an elderly or disabled adult is abused, neglected, or exploited, the law requires that your provider make a report to the Department of Social Services. Once this report is filed, your provider may be required to provide additional information.
- If you communicate a specific threat of immediate serious physical harm to an identifiable victim, and your provider believes you have the intent and ability to carry out the threat, we are required to take protective actions. These actions may include notifying the potential victim or the potential victim's guardian, contacting the police, or seeking hospitalization for you.
- If you threaten to harm yourself, your provider may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection. In any of these situations, based on your provider's assessment of your best interests, your provider will make every effort to fully discuss disclosures with you and will limit information to the minimum necessary disclosure. Please address your concerns or questions about health information privacy with your provider. Please note that the laws governing health information privacy can be quite complex and your provider is not an attorney. In some situations, you may wish to speak with an attorney about health information privacy.

Technology

In the interest of protecting patient privacy and confidentiality, we do not communicate with patients via social media and we will not respond to attempts to contact us via social media. Video or audio recording of our services is prohibited unless written authorization is provided both by you and the treating provider. Your provider may use email on a limited basis for scheduling purposes. Our primary mode of communication is by phone and fax.



INFORMED CONSENT FOR THERAPEUTIC SERVICES

Minors & Guardians

A minor of any age has the right to independently consent to and receive mental health treatment without guardian consent. If a minor receives treatment without guardian consent, information about that treatment cannot be disclosed without the minor's consent.

When a guardian consents to the treatment of a minor, the provider will disclose health information to guardians only at the provider's discretion. Privacy in mental health treatment is essential for treatment effectiveness, particularly with adolescents. If a provider believes that a minor is at risk of harming him/herself or others, the provider will notify a guardian and, if necessary, law enforcement. The provider will make every effort to discuss any disclosures with the minor. If parents of a minor patient are divorced, both parents have access to the minor's health information unless parental rights have been revoked by a court of law. In addition, both parents must consent to the minor's treatment.

Clinical Records

The law and standards of our profession require that we maintain a clinical record of your health information. Our practice maintains records in hard copy form and/or in a secure, encrypted electronic medical record (EMR) database. We will notify you promptly if we are aware that a breach of your clinical record occurs.

In most cases, you have the right to review and/or receive a copy of your clinical record upon written request. Your provider may refuse to release your record if he/she believes that examination of your record would be harmful to you. If that is the case, your provider may recommend that you review the record together. You also have the right to request that a clinical third party review your record to assess the potential for harm to you if you review your record.

In the event of your provider's death, disability, or departure from our practice, you agree that our practice may appoint a proper custodian, within the practice, to be responsible for the care and disposition of your clinical record.

We are legally required to adhere to the privacy practices described in this document and to provide you with a copy of this document. We never market or sell personal information for any reason.

Patient Rights

HIPAA provides you with several new or expanded rights with regard to your clinical record and disclosures of your protected health information. You have the right to:

- Request that your provider amend your record.
- Request restrictions on disclosures of health information from your clinical record.
- Request an accounting of some disclosures of protected health information that you have neither consented to nor authorized.
- Request information about where your clinical record was sent.
- Request that your provider record your complaints about our policies and procedures in your clinical record.
- Request a paper copy of this agreement.

For more information about your rights and responsibilities under HIPAA, please visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noti-cepp.html

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office. Effective Date of Privacy Practices: 10/4/19 Privacy Official: Courtney Morrison, 703-241-2664

Treatment By Residents

In our practice, you may receive treatment from a clinical resident who practices under the supervision of a licensed clinical supervisor. Resident providers are bound by the same laws regarding privacy and mandated reporting as licensed providers with one exception -- residents are required to review cases with a clinical supervisor on a regular basis. Case reviews require a resident provider to disclose identifying patient information to a supervisor. The supervisor is bound to privacy and mandated reporting laws while serving in the capacity of supervisor. By signing this form, you acknowledge that you understand and are consenting to treatment by a therapy resident.

Consent For Treatment

You acknowledge that you have received, read (or had read to you) and understand the above listed policies and procedures. You commit to participating in treatment and paying all fees for services rendered. You also acknowledge you have received information related to your rights according to HIPAA (Notice of Privacy Practices & Confidentiality). By signing this document, you understand that it represents an agreement between you and the practice/provider. You may revoke this agreement in writing at any time. You understand that revoking this consent will be binding unless the practice/provider has taken action in reliance on it, including but not limited to: obligations imposed on the practice by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Signature of Patient (or guardian)

Printed Name

Date

Signature of Provider

Date