CONSENT OF PARTICIPATION IN THERAPEUTIC SERVICES

I, ____, agree to participate in therapy.

(Print Name)

I have been informed of the services that will be rendered to include but not limited to: INDIVIDUAL THERAPY; FAMILY THERAPY; GROUP THERAPY; PSYCHIATRIC SERVICES.

ACKNOWLEDGEMENT OF RECEIPT OF HANDBOOK

Notice of Privacy Practices and Confidentiality Agreement

- Explanation of Mental Health Procedures
- Consent and Authorization for Electronic Communication
- Notice of Rights and Responsibilities
- Complaint Policy and Procedure
- Crisis Management Information
- Emergency Evacuation Procedures
- Discharge, Transition, and Referrals Procedure
- Fees and Financial Obligations

Please initial, in the box, acknowledging that you have read, received and agreed to the above information, located in the client handbook.

POLICY ON FINANCIAL OBLIGATIONS

Fees and Financial Obligations:

Prior to consenting to treatment Innovative Therapeutic Services (ITS) will discuss the estimated cost of payment and payment options with the client. ITS billing policy states that if a client does not have insurance coverage, the client may be billed by Innovative Therapeutic Services, CORP. For clients with insurance, services will be billed by Innovative Therapeutic Services through the client's insurance company. It is the client's responsibility to know their insurance benefits and whether or not the services they are to receive are a covered benefit. The client will be responsible for any co-pay or balance due that Innovative Therapeutic Services is unable to collect from the insurance carrier for whatever reason. If there is a copay, copays are collected at the time of service. Medicaid clients are exempt from any financial obligations to Innovative Therapeutic Services. Medicaid recipients will not be billed for any missed appointments and will not be charged for any services.

Fees and Co-Payments/Co-Insurances/Deductibles for Privately Insured Clients

Privately insured clients are responsible for paying all fees and/or co-payments prior to initial and subsequent therapeutic sessions (e.g. individual therapy, group therapy, couples therapy, etc.). Clients are required to satisfy each co-payment *prior to scheduled appointment*. Failure to pay all fees and/or co-payments will result in ITS cancelling subsequent appointments until all fees and/or co-payments are satisfied.

Privately insured clients are responsible for updating ITS staff if any changes to their address, phone number, and insurance information prior to scheduled appointment.

ITS reserves the right to verify client's insurance information and will notify clients fees and/or co-payment due *prior to scheduled appointment.* ITS also reserves the right to send the client an invoice for outstanding fees and/co-payments to the client's provided address.

Cancellations and Missed Appointments:

When an appointment is scheduled, that time is reserved specifically for you. If the appointment is missed or cancelled without enough notice, the therapist is unable to make use of that time. Therefore, sessions must be cancelled 24 hours in advance. If a client does not give 24 hour notice it is considered a "no show". If a client no shows two times within the span of 60 days, the client will have to wait 30 days before being able to schedule a follow up appointment, unless the client is experiencing a mental health crisis.

Please initial, in the box, acknowledging that you have read and agreed to the information above.

______________________________________ ____________________

Client/Parent/Guardian Signature **Date**

CLIENT INTAKE

Referral Date: _______________ Referral Source: ____

Mr/Mrs/Ms/Miss / Client Name: ___________________________________ Client DOB: _________________

Client Social Security #: ______-____-______ Medical Assistance # (If Applicable): ________________________

Address: _____________________________________, ____________________, ______________, __________
Street City State Zip

Phone: (Cell) ___________________ (Home) _____________________ (E-mail) __________________________

☐ *Please place a checkmark in the box if you currently do not have a primary care doctor; however, you will inform ITS when a PCP is attained.*

Primary Care Doctor: ____ ____________________________
Name Phone Number

Address: _____________________________________, ____________________, ______________, __________
Street City State Zip

Case Manager (If Applicable): _________________________________ ____________________________
Name Phone Number

Primary Insurance Carrier's Information

Name: ____________________________ DOB: _________ Insurance Customer Service #: _______________

Member ID Number: ___________________________ Group Number (if applicable): _______________________

Emergency Contacts *(Please provide information for those who may be contacted in case of an emergency):*

Name: ____

Address: ____

Phone Number: ___________________________

Name: ____

Address: ____

Phone Number: ___________________________

☐ *Please place a checkmark in the box if you do not have a second emergency contact.*

If client is a minor, please complete a third emergency contact.

*Name: ____

Address: ____

Phone Number: ___________________________

☐ *Please place a checkmark in the box if you do not have a third emergency contact.*

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Our Privacy Practices: Innovative Therapeutic Services, CORP (ITS) promises to maintain the confidentiality of your protected health information (PHI). PHI is health information about you that we have in our records. We will not share this information, in whole or in part, with any person or entity without your consent. In addition, we commit to delivering our services in a manner that maintains confidentiality. We will coordinate services with primary care physicians, referring agencies, schools or other stakeholders with your written consent.

Federal & State Laws: We are required by federal regulations called the "HIPAA Privacy Regulations" to protect the confidentiality of your health information. We are also required to comply with state laws that are often more stringent than the federal regulations. This, in essence, gives you double protection.

Authorization to Disclose PHI: It is our practice to obtain your authorization or consent before we disclose your PHI to another person or entity. You may revoke your authorization or consent at any time and for any reason.

How We Use Your Protected Health Information: We use your PHI solely for treatment, payment and health care operations. For example, we may use your PHI to plan and provide your care and treatment; communicate with health care professionals; obtain payment for our services; educate and train our staff; and assess and improve our services. We are also permitted to use or disclose your health information if required by law.

Your Rights: You have a right to request a restriction on certain uses and disclosures of your PHI; inspect and copy your PHI; request amendments to your PHI; and obtain an accounting or list of disclosures of your PHI. This access does not include records from outside agencies, such as hospitals, DOR, etc. Such access to the file must be authorized by the Program Director, with a notation of date and time entered in the file. If it is felt that, it would not be in the best interest of the member to access the file, a written summary of the file contents will be provided to the individual. A staff member must be present while the record is being reviewed by the member to ensure that nothing is removed or changed within the file contents. A member who disagrees with the contents of his/her records will have the opportunity to submit corrections/amendments, which would be included in the records.

Research: No sessions will be recorded without the written consent of the client. No information will be reviewed for research without the written consent of the client.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages text messages, emails postcards, or letters).

Our Duty: It is our duty to provide you with a copy of this disclosure statement for your personal records at the point of intake. A duplicate can be provided for you at any time upon request. With few exceptions, our conversations are confidential. State law, federal regulations and our code of ethics specifically guarantee this confidentiality. There are some situations, however, in which confidentiality cannot be guaranteed.

They fall within the following categories:

- We must notify appropriate persons if we feel you may harm another individual.
- We must report any occurrence of child abuse (past or present), or the abuse, neglect or exploitation of the elderly.
- We will have to respond to a subpoena accompanied by a court order.
- We will have to respond to any situation in which we believe you may harm yourself.

CLIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

CLIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Client Name: ______________________________ **Date of Birth**: ____________________

- I,_____________________________, acknowledge that I have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

- I,_____________________________, consent to the use and disclosure of my personal health information by your office for Treatment, Billing / Payment and Health care operations as outlined in the NOTICE OF PRIVACY PRACTICES.

____ ________________________

Client/Parent/Guardian Signature **Date**

____ ________________________

Print Name (If not signed by client) **Date**

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, the Undersigned, authorize: **Innovative Therapeutic Services** and staff members to release and receive written and/or verbal information related to the client listed to the person or agency indicated below:

Client Name: ___________________________ **Date of Birth**: __________________

Once completed and signed, this authorization will remain in effect until: ____________________
(one year from date signed)

The Mental Health Information Authorized for Release includes: (Please check all that apply)

☐ Copies of Records ☐ Discharge Summaries ☐ Consultation

☐ Immunization Records ☐ Other Information: ________________________________

Primary Care Doctor (PCP): ____

Address: ____

Phone #: ________________________ Fax #: __________________________

Purpose of Release: Coordination of Care_____________________________________

☐ **I currently do not have a primary care doctor; however, I will inform ITS when a PCP is attained. *Please sign below.***

☐ **I do not wish to have ANY information released to the client's primary care doctor (PCP). *Please sign below.***

I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed above, nor will it affect my eligibility for benefits. I understand that I may inspect and have a copy of the health information described in this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that this professional or facility will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

I acknowledge that the information to be used or disclosed as a result of this Authorization may include records that are protected by other federal and/or state laws applicable to substance abuse. I specifically authorize the release of confidential information relating to drug and/or alcohol abuse, psychiatric, HIV results and or AIDS information. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information. 42 CFR 2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

____ ______________________

Client/Parent/Guardian Signature **Date**

____ ______________________

Print Name (If not signed by client) **Date**

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, the Undersigned, authorize: **Innovative Therapeutic Services** and staff members to release and receive written and/or verbal information related to the client listed to the person or agency indicated below:

Client Name: ____________________________ **Date of Birth**: ___________________

Once completed and signed, this authorization will remain in effect until: _____________________
(one year from date signed)

The Mental Health Information Authorized for Release includes: (Please check all that apply)

☐ Copies of Records ☐ Discharge Summaries ☐ Consultation

☐ School Visitation ☐ Immunization Records

☐ Psychiatric Records ☐ Other Information: _________________________________

School: ____

Address: ____

Phone #: _____________________ Fax #: ___________________________

Purpose of Release: Coordination of Care________________________________

☐ **I do not wish to have ANY information released to the client's school.** ***Please sign below.***

I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed above, nor will it affect my eligibility for benefits. I understand that I may inspect and have a copy of the health information described in this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that this professional or facility will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

I acknowledge that the information to be used or disclosed as a result of this Authorization may include records that are protected by other federal and/or state laws applicable to substance abuse. I specifically authorize the release of confidential information relating to drug and/or alcohol abuse, psychiatric, HIV results and or AIDS information. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information. 42 CFR 2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

____ _______________________
Client/Parent/Guardian Signature **Date**

____ _______________________
Print Name **Date**

Telehealth Consent Form

Tele-health is a form of two-way, real time, video and audio conferencing, which provides services to clients and their families who are unable to travel to a clinic or who live in rural areas where psychiatric service is hard to find. Via telepsychiatry, we provide a wide array of services including but not limited to diagnosis and assessment, medication management, individual and couples therapy and more. Services are provided by qualified and licensed providers and it does not require transportation of the patient to the office. To qualify for telehealth services the patient must be an established patient and have consented to telehealth services. Electronic systems used is a high quality, real-time (synchronous) audiovisual link using HIPAA-compliant telehealth platform to protect the confidentiality of patient identification, however as with any other technology devices, we can’t guarantee confidentiality.

Expected Benefits:

- Improved access to high quality care and continuity of care
- Enables patient education and compliance
- More efficient medical evaluation and management
- Allows for timely and convenient service
- Obtaining expertise of a distant specialist
- Cost efficient

Eligibility to Participate in Telehealth:

- Must be 18 years or older to participate in telehealth or have parent present
- Must provide valid state issued photo ID at the time of each session
- Must be in the state of Maryland during time of session
- Must have access to a computer or smart device that will allow both audio and video connection that is of sufficient quality
- Must be in a private or isolated setting during time of session
- Must always maintain a valid phone number in records

By signing this form, I understand the following:
Please **initial** each numbered line, indicating your understanding and consent.

_____1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.

_____2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth through the course of my care at any time, without affecting my right to future care or treatment.

_____3. I understand that I have the right to inspect all information obtained and recorded through the course of a telehealth interaction and may receive copies of this information for a reasonable fee.

_____4. I understand that a variety of alternative methods of mental health and medical care may be available to me, and that I may choose one or more of these at any time.

_____5. I understand that telehealth may involve electronic communication of my personal mental health and medical information to other mental health and medical practitioners who may be located, in other areas, including out of state.

_____6. I understand that it is my duty to inform my clinician, nurse practitioner and or psychiatrist of electronic interactions regarding my care that I may have with other healthcare providers.

______7. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

______8. I understand that Telehealth uses a high quality, real-time audiovisual link using HIPAA compliant platform. If there is any disruption in the connection, clinician nurse practitioner and or psychiatrist will try to re-establish the connection as soon as possible, if we are unable to do so, we will call you immediately on your phone number in our files.

_____9. I understand that in case of an emergency, my clinician, nurse practitioner and or psychiatrist will call 911 to get me appropriate care, as my clinician, nurse practitioner and or psychiatrist is not physically present with me, my clinician has limitations to assist me.

_____10. I understand that my clinician, nurse practitioner and or psychiatrist has the right to use his/her own judgement to determine if I am suitable and appropriate client for using Telehealth.

_____11. I understand that my clinician, nurse practitioner and or psychiatrist may request me to be seen in the office as and when needed and I will comply with these requests.

_____12. I understand that the first visit will be a face to face visit in the office with my psychiatrist

_____13. I understand and agree that telehealth session will not be used for emergency visits or crisis intervention. During emergency situations I agree to follow up in the office for face to face visit

Patient Consent to The Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my physician or such assistants as may be designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care, including but not limited to diagnosis and treatment plan.

Patient Name: ______________________________________ DOB: ____________________________

Patient Signature: ____

Parent/Guardian Signature: ____

Date: ____