620 Colonial Park Dr
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**P:** 678-439-0017
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# Mental Health and Wellness Treatment Agreement Policy and Consent

Welcome to Psychiatry and Wellness of Georgia. This Mental Health Informed Consent document contains important information about our professional services and business policies. Please read carefully and ask questions that you may have. When you sign this document, it will represent an agreement between us.

**MENTAL HEALTH DEFINED**: Mental Health Services includes in person meetings and remote delivery of health care services via technology assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to video, internet, a smartphone, tablet, PC desktop system or other electronic means.

**BENEFITS/OUTCOMES**: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in mental wellness treatment may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in mental wellness treatment can lead to a greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of mental wellness treatment.

**EXPECTATIONS:** For clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. The journey to mental wellness is a marathon, not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the process, we identify goals, review progress, and modify the treatment plan as needed.

**SERVICES:** You agree to receive psychotherapy, and medication management if needed which may involve the off-label use of medications. You understand the risks, benefits, and alternatives of receiving these services and have had the opportunity to ask questions. The indication for medication that are part of your treatment have or will be discussed with you. You understand that on occasion, psychiatric medication may be used without the FDA approval. You accept and comply to the advantage or disadvantage of this usage. If you have any questions, please contact the location provider.

- Medication refills will be considered on a case to case basis and must be approved by the provider. If a refill is processed outside of the allotted appointment time, **the cost would be $35.00.**

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**APPOINTMENTS AND CANCELLATIONS**: You are responsible for attending each appointment and agree to adhere to the following policy. ***If you cannot keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment before 24 hours of the scheduled appointment time or you will be charged.***

- For *returning* patients, same day cancellation fee is **$50.00**.
- For **new** patients, same day cancellation fee is **$100**.

If you cancel or reschedule more than once, we may re-evaluate your needs, desires, and motivations for treatment.

**FEES/INSURANCE**: We are **in network** with most insurance companies. Please verify with our office before scheduling an appointment. We are **not in network** with community and state plans such as Medicaid. For out of network patients:

- The cost of an appointment for a new patient is **$300.00.**
- The cost for follow up appointments is **$150.00.**

You will be charged the day of your session **before** your session time. The acceptable form of payment is a credit/debit card on file. If a scheduled appointment time is missed or canceled in less than 24 hours, please refer to the "Appointments and Cancellations" policy above**.** We can provide you with an itemized receipt/superbill that may allow you to get reimbursement from your insurance company usually between 60-80% after your deductible is met. The clinician reserves the right to terminate the treatment relationship if more than 3 sessions are missed without proper notification. The clinician charges his/her hourly rate in quarter hours for phone calls over 15 minutes in length, email correspondence, reading assessments or evaluations, writing assessments with necessary professionals (with your permission) for continuity of care. If possible, please attach a copy of your ID and insurance card.

**COPIES OF MEDICAL RECORDS**: Should you request a copy of your medical records; the cost is $25.00. Payment for your medical records will be due prior to or upon receipt and can be picked up at the office. Please allow at least 2 weeks to prepare medical records. At this time, we are not completing disability paperwork.

**CONTACTS:** Office hours are flexible from Monday - Thursday 8:00 AM – 5:00 PM, Friday 8:00 AM- 12:00 PM. If you need to contact the clinician for any reason, please call 678-439-0017, leave a voicemail, and a return call will be made as soon as possible. All calls will be answered during business hours. *We do not provide 24/7 on-call coverage or services*. **We are closed weekends and holidays.**

**EMERGENCIES/ CRISES**: If you are in a crisis, **do not** communicate this via email or on social media. If you are unable to reach our office by phone and require immediate attention, dial 911 or head to your nearest hospital emergency room. You can also access emergency assistance by calling the National Suicide Prevention Lifeline at 1- 800-273-8255. Text HOME to 741741 from anywhere in the United States, anytime, regarding any type of crisis. Crisis Text Line serves

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anyone, in any type of crisis, providing access to free, 24/7 support and information via a medium that is trusted. If either you or someone else is in danger of being harmed, dial 911 or go to your nearest emergency room.

Anything said in mental health and wellness treatment is confidential and may not be revealed to a third party without written authorization, ***except*** for the following limitations:

- **Child/Adult Abuse**: Child abuse, child neglect, adult abuse and neglect which include but are not limited to domestic violence in the presence of a child, child-on-child sexual acting out/abuse, physical abuse, vulnerable adult abuse, or neglect etc. If you reveal information about any of the following, we are required by law to report this to the appropriate authority.

- **Self-Harm / Harm to others**: Threats, plans, or attempts to harm oneself or another person. We are permitted to take steps to protect the client's safety, which may include the disclosure of confidential information as well as mandatory reporting to the authority.

- **Court Orders & Legal Issued Subpoenas**: If we receive a subpoena for your records, we will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. We will contact you twice by phone. If we cannot get in touch with you by phone, we will send you written correspondence. If a court of law issues a legitimate court order, we are required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, we are required to comply with a court order.

- **Law Enforcement and Public health**: A public health authority is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability to a health oversight agency and gain limited information (such as name, address DOB, dates of treatment, etc.) for a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.

- **Governmental Oversight Activities / Court-Ordered Therapy:** To an appropriate agency, information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for public benefits or services when your mental health is integral to the claim for benefits or services or specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence. If treatment is court-ordered, the court may request records or documentation of participation in services. We will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Victim of a Crime**: Limited information, in response to a law enforcement official's request for information about you if you are suspected to be a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.

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● **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/process notes", except if the third party is part of the medical team. If mental health and wellness sessions involve more than one person, each person over the age of 18 MUST sign the release of information before the information is released.

● **Fee Disputes**: In the case of a credit card dispute, we reserve the right to provide the necessary documentation (i.e., your signature on the "Credit Card on File") that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on the account, a bill will be sent to the home address on the intake form unless otherwise noted.

**DRUG SCREEN POLICY**: During initial assessment and occasionally during treatment you may be asked to provide a urine screen. The results help the provider know that the patient is taking medications prescribed and verify the patient is not taking other unauthorized substances that may affect patient mental health or interact with medications. Cost for urine drug screen is $15.00 and occasionally is sent to the lab, and the fee is mostly covered by insurance.

- **Stimulants** - If you are prescribed stimulants our physician requires, periodic drug screen, EKG yearly, and blood pressure every 3 months or less if needed. It is your responsibility to take keep medication safe. You are not to share medication with anyone or adjust doses without provider approval. No replacement or early refill for stimulant will be provided.

● **Social Media**: In a digital modern world we use our professional social media platforms to advocate for mental health and wellness while providing educational information. Social media should not replace mental health and wellness treatment. No friend requests on our **personal** social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) if you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. We cannot be held liable if someone identifies you as a client. Please do not contact us through any social media site or platform. They are not confidential and may become part of a medical record.

● **Communication**: If you are experiencing issues that need to be addressed by your provider, and they are not life-threatening emergencies, please schedule an appointment to discuss these matters further. Electronic messages cannot take place of a scheduled or missed appointments. Do not email, text, or leave a voicemail if you are experiencing a life-threatening event. Call 911 or go to your nearest emergency room.

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**PARTICIPATION IN TELEMENTAL HEALTH CONSENT:**

I understand that telemental health involves the communication of my mental health information in an electronic or technology-assisted format. I understand that telemental health services can only be provided to clients, including myself, who are residing in the state of at the time of this service.
I understand that all electronic communications carry some level of risk. These risks include but are not limited to:
1) It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
2) Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
3) Despite reasonable efforts on the part of my therapist/provider, the transmission of mental health information could be disrupted or distorted by technical failures. I understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversations.

I understand that telemental health billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

I understand that if am planning to get pregnant, or if I think am pregnant, I will notify my provider immediately. I understand all medications have the potential to cause harm to a fetus some severe than others.

I understand that information, including mental health records, are governed by federal and state laws that apply to telemental health. This includes my right to access my own records (and copies of my records). I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others. I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. The therapist/provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

I understand that electronic communication cannot be used for emergencies or time-sensitive matters. I understand and agree that receiving mental health care via telehealth may limit my therapists/providers ability to fully care for my needs. As the client, I agree to accept responsibility for following my therapists/providers recommendations—including further in person assessment testing or office visits. I understand that my therapist/provider may need to forward my information to an authorized third party with my consent. Therefore, I have informed the therapist/provider of any information I do not wish to be transmitted through electronic communications. To the extent permitted by law, I agree to waive and release my therapist/provider and his or her institution or practice from any claims I may have about the

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telemental health visit. I understand that electronic communication should never be used for emergency communications or urgent requests. For all emergencies, please call 911, or go to the nearest Emergency room.

## TREATMENT CONSENT FORM

By signing the Mental Health Informed Consent, you voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the Provider to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment, or services at any time.

If a "super bill" is requested, you authorize the release of treatment and diagnosis information necessary to process "super bills" for services to our insurance company. You acknowledge that you are financially responsible for payment regardless of insurance coverage. You understand, in the event that fees are not covered by insurance, the practitioner may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

*Your signature signifies that you have received a copy of the* "Mental Health and Wellness Treatment Agreement, Policies and Consent" for your records.

Client's Printed Name: _____

Client's Legal Representatives Name: _____

*If client is a minor / has a guardian*:

Parent / Guardian Printed Name: _____

The CLIENT MUST sign the consent if they are able to do so. The only exceptions are if the client is a minor or has a legal document giving permission for someone else to sign on their behalf.

_____

Client / Clients LEGAL Representative / Parent or Guardian Signature

_____

Date