**Superior Health and Wellness Group**
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Welcome to Superior Health and Wellness. This document (**the Agreement**) contains important information about our professional services and business policies. A separate document which will be provided for your review contains summary information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy protection and patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA requires that you are provided with a Notice of Privacy Policy (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice explains HIPPA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before your next session. We can discuss any questions between us. You may revoke this agreement in writing at any time.

## Psychiatry and Mental Health Services

### PSYCHIATRIC SERVICES

Superior Health and Wellness provides psychopharmacology (medication) to child, adolescent, and adults. During your initial meeting, an evaluation of current and past symptoms will be completed. Your past medical and psychiatry history will be useful in this evaluation. We will decide together if medication is desirable or, if you are already on medication, whether it is working as well as it should. Medication does not solve your problems; however, it can control your symptoms so that you are free to do the work and growth you need to do in therapy and in your life.

### PSYCHOTHERAPY

Superior Health and Wellness offers the following counseling evidence-based services.

- Children
- Adolescent
- Adult
- Family
- Marriage
- Relationship
- EAP Services
- Groups

Counseling is not easily described in general statements. It will vary based on the therapist, patient, and the problems you are experiencing. There are many different researched based counseling methods we may use to deal with the problems you hope to address. Therapy calls for a very active effort on your part. For the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Remember: We base our therapy and recommendations on what you tell us and what we observe. Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger,

frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience in the counseling experience.

**MEDICATION MANAGEMENT MEETINGS**

Our first session will last about 45-60 minutes. During this time, we can both decide if I am the best person to provide the psychiatric and mental health services you need to meet your treatment goals. If we continue meeting, for medication management I will normally schedule 30-minute session at intervals, which can be as short as one or two weeks or as long as two or three months, depending on how you are feeling and any changes in your medication. Between sessions you are always free to reach out to me if you are having a side effect or if anything concerns you. **Once an appointment time is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control.) If you do not cancel 24 hours in advance, you will be billed $44.50, one-half of the medication management appointment fee. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. (If it is possible, I will try to find another time to reschedule the appointment.) Please be aware that our practice does make reminder calls, however we will only provide one notification. Please understand it is the patient's responsibility to remember their scheduled appointment.**

**PSYCHOTHERAPY MEETINGS**

Our first session is very similar to the medication management visits and will last about 45-60 minutes. During this time, you and your therapist will decide if therapy is right for you and if we are able to meet your treatment goals. If we continue meeting, visits will normally be scheduled at 45-50-minute session at intervals, which can be as weekly or biweekly, depending on what you and your therapist decide. **Once an appointment time is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control.) If you do not cancel 24 hours in advance, you will be billed $64.50, one-half of the psychotherapy appointment fee. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. (If it is possible, I will try to find another time to reschedule the appointment.) Please be aware that our practice does make reminder calls, however we will only provide one notification. Please understand it is the patient's responsibility to remember their scheduled appointment.**

**PROFESSIONAL FEES**

**My fee for the initial interview is $209.00, on-going medication management fees are $89.00 per session and psychotherapy is $129.00 per session. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time upfront, including preparation and transportation costs, even if I am called to testify by another party. (Because of the difficulty of legal involvement, I charge $350.00 per hour for preparation and attendance at any legal proceeding.)**

**CONTACTING ME**

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered my front desk staff. After hours you may get the voice mail that we monitor frequently. We strive to return your call on the same day you make it, however weekends will lead into the following week. Please note **WE ARE NOT A CRISIS CENTER**, **If you are unable to reach me and feel that you can't wait for a return call, go to the nearest emergency room.** If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary

## LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychiatrist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPPA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities as follows:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations in your Clinical Record (which is called "PHI" in my Notice of Psychiatrist's Policies and Practices to Protect the Privacy of your Health Information).
- You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services that we provided you, such information is protected by the provider-patient privilege law. We cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a government agency is requesting information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, we will disclose relevant information regarding that patient to defend our providers and practice.

There are some situations in which we are legally obliged to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

- If we receive information in my professional capacity from a child or the parents or guardian or other custodian of a child that gives us reasonable cause to suspect that a child is an abused or neglected child, the law requires that we report to the appropriate governmental agency, usually the statewide central register of child abuse and maltreatment, or the local child protective services office. Once such a report is filed, we may be required to provide additional information.
- If a patient communicates an immediate threat of serious physical harm to an identifiable victim, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. Please not the laws governing confidentiality can be quite complex.

## PROFESSIONAL RECORDS

The laws and standard of the medical profession require that we keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them in my presence or have them or have them forwarded to another mental health professional so you can discuss the contents. We are allowed to charge a copy fee of 75 cents per page (and for certain other expenses). If we refuse your request for access to your records, you have a right to review, which I will discuss with you upon request.

## PATIENT RIGHTS

HIPAA provides you with several expanded rights regarding your Clinical Records and disclosures of protected health information. These rights include requesting that records are amended; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to not authorize; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. We are happy to discuss any of these rights with you.

## BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. (In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment installment plan.)

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information that is released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. (If legal action is necessary, its costs will be included in the claim.)

## INSURANCE REIMBURSEMENT

For us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled however, you (not your insurance company) are responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers.
You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. (Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your psychotherapy.)

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in our computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with the national medical information database. We will provide you with a copy of any report that is submitted, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above (unless prohibited by contract).

***YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.***

_____ _____

Patient/Guardian Signature Patient/Guardian printed name

_____

Date

## CONSENT TO TREATMENT

You are about to take an important step in your mental wellbeing. As your mental health provider, we will be entering into a protected relationship. Treatment might involve a multidimensional family approach. Due to this, consent is needed for all those participating in sessions. We are treating you and we do our best to accurately diagnose you and design a comprehensive treatment plan that fits your goals and needs. This may include recommendations and treatments with certain types of therapy and/or medications. We will also work with your primary care physician to assure coordination of care.

By signing below, you do hereby seek and consent to take part in the treatment provided by Superior Health and Wellness Group, LLC. If you are attending group services, you also understand and consent that confidentiality still applies and that Superior Health and Wellness Group, LLC is not liable for group members breaking confidentiality. You also understand that developing a treatment plan with your provider and regularly reviewing your work towards the treatment goals are in your best interest. You agree to play an active role in this process. You understand that no promises will be made to you regarding the results of your treatment, or any other procedures provided by my mental health provider.

_____ _____

Patient/Guardian Signature Patient/Guardian printed name

_____

Date

## INSURANCE AUTHORIZATION/RELEASE OF INFORMATION

I, the subscriber named below, authorize Superior Health and Wellness Group, to release any and all information pertaining to my treatment to any third-party payer (such as my insurance company or a government agency) as needed to determine a claim for payment for such treatment and diagnosis. Please note that insurance is considered a method of reimbursing the client for fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, while others pay a percentage of the charge. I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time, and not to exceed 60 days

_____ _____

Patient Guardian Signature Patient/Guardian printed name

_____

Date

**TELEHEALTH CONSENT**

I understand and agree to receive telemental health services from my counselor/provider. This means that my counselor/provider and I will, through a live interactive video connection, meet for scheduled psychotherapy sessions under the conditions outlined in this document and the Superior Health and Wellness Agreement form.

I understand the potential risks of telemental health, which may include the following:

1) the video connection may not work, or it may stop working during a session;
2) The video or audio transmission may not be clear; and
3) I may be asked to go to my counselor/provider's office in person if it is determined that telemental health is not an appropriate method of treatment for me.

I recognize the benefits of telemental health, which may include the following:

1) reduced cost and time commitment for treatment due to the elimination of travel;
2) ability to receive services near my home or from my home; and
3) access to services that are not available in my geographic area.

I give my consent to engage in psychotherapy via videoconferencing. I understand that my therapist uses a HIPAA-compliant technology to transmit and receive video and audio and stores all notes and information related to my treatment in a manner that is compliant with state and federal laws I understand that it is my responsibility to ensure that my physical location during videoconferencing is free of other people to ensure my confidentiality. Furthermore, I understand that recording my sessions is prohibited. I understand that I have the option to request in-person treatment at any time, and my therapist will assist in scheduling this or make a referral if travel to the therapist's office is not feasible for me. I understand that closer providers may not be available depending on my location. I understand the limitations to confidentiality with my therapist include reasonable belief that I am a danger to myself or others. I understand that, if my therapist reasonably believes that I plan to harm myself or someone else, my therapist will contact local emergency services to come to my location and ensure my safety.

Patient/Guardian Print Name _____

Patient/Guardian Sign Name _____

Date _____

**PSYCHIATRIC EMERGENCY**

My signature acknowledges, In the case of a psychiatric emergency, I will call 911 or go to the nearest hospital.

Patient/Guardian Print Name _____

Patient/Guardian Sign Name _____

Date _____

**AUTHORITY TO CONSENT**

I certify that I have the legal authority to consent to treatment, medication, release of information, and all legal issues involving the above-named client. If my status as legal guardian should change, I will immediately notify the agency of the name, address, and telephone number of the person who has assumed guardianship of the above-named client. I consent for the above-named client to participate in mental health assessment, treatment through Superior Health and Wellness Group. I understand that I may revoke consent for the above at any time; however, I cannot revoke consent for action that has already been taken.

Patient/Guardian Print Name _____

Partient/Guardian Sign Name _____

Date _____

***DISCLAIMER: By signing your name, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature.***