RELIEVE BEHAVIORAL HEALTH AND WELLNESS CENTER

INFORMED CONSENT FOR TREATMENT

I, _____(print name), agree, consent, and give permission to participate in counseling and/or psychopharmacology services offered and provided by Relieve. I understand that Relieve Behavioral Health and Wellness Center is responsible based on this informed agreement to participate in treatment in this practice.

CONDITIONS FOR TREATMENT

1. It is your responsibility to maintain appointments and understand the policy and procedures of this practice. Please review medication policy and financial agreement.

2. Clients are expected to adhere to the treatment plan designed and discussed with you by your provider. Each treatment plan is different. Failure to comply with your treatment plan could result in premature termination of your treatment.

3. You must allow at least 48 hours for the office to return a phone call or email request.

4. In case of emergency clients should call 911, 988 or utilize emergency services, such as, walk in clinic, emergency room or 211.

Your confidentiality is protected under the HIPPA except in the following cases:

In the professional judgment of your provider, you:

- Intend to hurt yourself or someone else. In the case of the risk of endangering someone else, we have a legal duty to warn the victim. In these cases, we will notify the authorities.

- Intend to or have committed abuse of an elderly person.

- Intend to or have endangered the welfare of a minor.

This professional contract ensures that in all situations, other than those listed above, I will keep your case complexly confidential unless you request and give me permission to share your information with another party.

Client Signature: _____Date: _____

If client is under the age of 18:
Relationship to Patient: _____Print Name: _____
Signature: _____Date: _____

281 Hartford Turnpike
Suite #504, Vernon, CT
06066 Phone: 860-995-4268
Fax: 860-838-7600

RELIEVE BEHAVIORAL HEALTH AND WELLNESS CENTER

Financial Agreement and Credit Card Authorization Form

I agree to the following:

• All fees are due at the time of service.

• It is your responsibility to understand and navigate your insurance benefits. Relieve Behavioral Health and Wellness Center will submit your insurance claims and assist you in working with your insurance company. There may be exclusions and restrictions placed on your coverage depending on your individual plan. Not all services are a covered benefit in all contracts. You can utilize the member service number located on the back of your card for clarification on your coverage. You understand that you are responsible for any fees due to lack of coverage, denied coverage or not disclosing all information needed for billing purposes.

• We will require all commercial insurance clients to keep an active credit card on file with us. We will bill your insurance company first and upon their determination of benefits, we will only charge your credit card when they inform us of client responsibility. Balances may be paid by credit card, cash, or check. There will be a $30 fee for returned checks. Circumstances when your card would be charged include but are not limited to:

• missed or canceled appointments without 24-hour notice

• co-payments, deductible, and co-insurance any non-covered services and/or denial of services allocated to client responsibility

• any amount not paid by your insurance 60 days after a corrected claim has been file

• Non-payment. This will result after 30 days of nonpayment, and your account will be referred to a third-party debt collection agency. A collection fee of 15% will be added to the total unpaid balance.

• There is a 24-hour cancellation policy. If for any reason you are unable to attend a session, please contact the office directly and leave a message either by voice mail or email (farhiya.relievebhwc@outlook.com). It is extremely difficult to fill your last-minute cancelled session at short notice. Therefore, any scheduled appointment that is missed and/or not cancelled more than 24 hours in advance will be charged $100.00 late cancellation/no-show fee. This fee will be charged to your default credit card on file.

First Visit Deposit
To confirm your first appointment, we require a $100 deposit. This deposit serves as a commitment to your scheduled visit and will be applied toward any future copays, deductibles, or outstanding balances on your account.
Deposit Cancellation Policy:
• If you cancel your appointment with at least 24 hours' notice, your deposit will remain on your account to cover future costs.
• If you fail to attend your first visit or cancel with less than 24 hours' notice, your deposit will be forfeited.

Refund Policy:
• Upon leaving our practice, any unused portion of your deposit will be refunded to you.
This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Thank you for understanding our policies, which help us maintain availability for all patients. I understand the financial agreement and results of outstanding balances.
Client Signature (or financial representative) _____ Date: _____ If client is under the age of 18: _____ Relationship to Patient: _____ Print Name: _____ Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND POLICIES

To comply with HIPAA standards, each practice must obtain a signed acknowledgement that each patient has read and upon request may receive the Notice of Privacy Practices and Policies. A summarized version is available on our website. A full version of additional details will be given with an emailed request. Your signature will allow our practice to use or disclose confidential information (protected health information) for treatment, payment, or healthcare operations. I understand and agree to abide and consent to receive treatment, I understand and agree to abide by the late cancellation and missed appointment policy.

I have read the Notice of Privacy Practices and Policies from:

Relieve Behavioral Health and Wellness Center
281 Hartford Turnkpike Suite #504
Vernon, CT 06066

Patient Name: _____
Patient Signature: _____Date: _____

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Print Name: _____Relationship to Patient: _____
Signature: _____Date: _____

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RELIEVE BEHAVIORAL HEALTH AND WELLNESS CENTER

CONSENT FOR MEDICATION

I give my consent to be treated with medication as part of the individualized treatment plan at Relieve Behavioral Health and Wellness Center. I consent to take medication as prescribed by my medical practitioner and discuss any allergies, adverse reactions, and other medications I am currently prescribed. I understand not disclosing information or choosing to take medication outside the prescribed directions can cause serious side effects and increase health risks. I recognized that a licensed medical provider has evaluated, and recommended medication options based on evidence-based practice. I have discussed medication options, risks, side effects and benefits of medications being prescribed. I am aware that all medications have side effects, some may have very rare and serious side effects. I also understand that that a practitioner will monitor the medication and side effects and I will have access to a practitioner if I have questions or problems with the medications.

I agree to the following medication practice policies:

1. If prescription for controlled medication is lost, misplaced, or stolen, or if it is taken more than prescribed, I understand that the medication will not be re-prescribed.
2. I agree to keep all medication in a safe place to prevent medication theft from occurring.
3. I will not share or dispense any medication to another person.
4. I understand the risk of using prescribed medications with alcohol, illicit drugs, other prescribed or non-prescribed mood-altering substances. I will be taking precautions and disclose and discuss this with my provider.
5. I agree to take medication as written on the prescription. I agree not to increase, abruptly stop, or change the dosage of my medication without the approval of my provider.
6. I agree to report any stolen medication to the police and supply a copy of the police report for any replacement prescriptions to be considered.
7. I will disclose to my provider if I am being prescribed any controlled substances such as opioid medications or pain medications, substance use treatment medications, stimulants, or benzodiazepines from another provider.
8. If any severe reactions to the prescribed medication occur, I agree to call 911 seek emergency services through an emergency room or walk in clinic.
9. I agree to dispose of any expired or discontinued medications appropriately and will not save medications that are not currently being utilized or prescribed.
10. Refills will be made during office visits only.
11. I understand that refill requests will need at least 48 hours' notice.
12. I understand that medication recommendations are based on the individualized treatment plan with your licensed provider. There are circumstances which allow for the provider to deny specific medications or may discontinue medications. Immediate discharge from the practice will be given if the medication policy is not followed.

I understand and agree to the terms of this policy and guideline.

Client Signature: _____ Date: _____

Patient/ Guardian Signature: _____ Date: _____

If patient is under the age of 18:

Relationship to patient: _____

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CONSENT FOR TELEMEDICINE

This form is to be used in conjunction with but does not replace the signed service agreement and consent for treatment that is required for all clients receiving services from Relieve Behavioral Health and Wellness Center.

1. Policies and Procedures. All policies and procedures signed through Relieve Behavioral Health and Wellness Center apply when rendering telemedicine services via telehealth communication. You understand if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, we may determine that you need a higher level of care or in person treatment and referral resources will be given.

Telehealth may not be the most effective form of treatment for all individuals or presenting problems. If it is believed the client would benefit better from another form of service (e.g. face-to-face sessions) or another provider, an appropriate recommendation will be made.

2. Potential Risks of Telehealth Services. Telemedicine is a subset of telehealth services that uses online, interactive videoconference software to provide mental health services from a distance. Telehealth does not include the use of fax, email or videotelephony products such as Facetime and Skype. You understand that there are some potential risks of using telehealth platforms.

- Technological failures such as unclear video, loss of sound, poor internet connection, or loss of internet connection.
- Nonverbal cues might be more difficult to observe and interpret during client interactions.
- Must electronically share and sign practice consent forms and accept risks that come with transmitting information and documents over the internet

3. Eligibility. You understand that Relieve Behavioral Health and Wellness Center is only able to provide telemedicine services to clients located in the state where the clinician is licensed in. All providers are licensed to practice in the state of CT. If you have additional questions regarding telehealth services, please contact the office. Clients must present a valid ID before the initial consultation and provide a copy for the medical file. You agree to inform us of the address where you are at the beginning of every TeleMental Health session. You agree to inform the provider of the nearest hospital or crisis center in your primary location that you prefer to go in the event of a mental health emergency.

4. Limitations of Telehealth Therapy Services. You understand that TeleMental Health services has limitations. There can be a risk of misunderstanding one another when communication lacks visual or voice cues. For example, if video quality is bad, if the sound quality is poor. There may be a disconnection. This can be frustrating and interrupt the normal flow of personal interaction. Please know that we have the utmost respect and positive regard for you and your well-being. Please let us know if you think that we may be missing important information.

5. Client Expectations during Telehealth Session.

- Mac/PC/Chromebook, smartphone or tablet with camera, microphone, and speakers
- Internet connection with at least 750kb download and upload speeds
- Access to Google Chrome or Mozilla Firefox (latest release versions) web browsers
- Proper lighting and seating to ensure a clear image of each party's face
- Dress and environment appropriate to an in-office visit
- Engage in sessions in a private location where you cannot be heard by others

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• Only agreed upon participants will be present; the presence of individuals unapproved by both parties will be cause for termination of the session

• Client must disclose the physical address of their location at the start of the session; unknown locations will be cause for termination of the session

• Client shall provide a phone number where they can be reached in the event of service interruption.

You understand that you are responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, internet or phone charges, software, headset, etc. If you are unable to afford these, please let me know as we can discuss alternative options for care.

6. Privacy and Confidentiality. The current laws that protect privacy and confidentiality also apply to the Telehealth services. Exceptions to confidentiality are described in the Notice of Privacy Practices. All existing laws regarding client access to mental health information and copies of mental health records apply. TeleMental Health services are provided through the HIPAA compliant, secure software. No permanent video or voice recordings are kept from Telehealth sessions. Clients may NOT record or store video from sessions.

7. In Case of Technology Failure. I understand that if a technological failure occurs during our Telehealth session, the most reliable backup plan is via telephone. Please make sure you have a phone with you, and we have that phone number. If we get disconnected from a session, please restart the session. If we are unable to reconnect within 10 minutes, please call the office. If we are on a phone session and we get disconnected, please call us back or contact the office to schedule another session.

8. Payment Procedures. I understand that I must pay for all services including Telehealth services. The credit card placed on file via the Client Portal will be charged following each session unless other arrangements have been made. It is up to the client to notify Relieve Behavioral Health and Wellness Center before the end of the session if they wish to use a different credit card for payment and change their credit card on file.

9. Consent for Telehealth Treatment.I hereby consent to engage in Telehealth services with Relieve Behavioral Health and Wellness Center. I understand that TeleMental Health includes mental health care delivery, diagnosis, consultation, medication management treatment, transfer of medical data, and education using interactive audio, video and/or data communications. I understand that telemedicine also involves communication of my medical and mental health information. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment with written notice.

I understand that I have the right to opt out or refuse telehealth services at any time.

I consent to receiving one or more services via telehealth [___]

I do not consent to receiving one or more services via telehealth [___]

Print Name: _____ Signature: _____

Parent/Guardian Signature (if Applicable): _____

Print Name of Relationship to Client: _____Date: _____

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