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Informed Consent for Treatment

You have certain rights and responsibilities when consulting a mental health professional. Some of these are listed below:

1. The Right to Refuse and End Treatment

Any adult has the right to refuse any therapy at any time. For children, this right belongs to the parents. Of course, if you are unhappy or have any questions about your treatment, please speak to me about it. In any case, it is your right to stop seeing me without discussion if you so desire. You can also end treatment at any time. I suggest you try to schedule at least one last session to review your progress, continued needs, and future recommendations.

2. The Right to Choose the Best Treatment Provider

There are many different professionals who offer mental health services and many different ways of working with human problems. No professional can offer the best treatment for every type of problem. It is your right and responsibility to choose the one that best fits your needs. If we are not a good match, I encourage you to talk to me about it and we will either revise your treatment plan or refer you to someone who may be better suited to your needs.

3. The Right to Privacy

This issue is dealt with extensively in the attached Privacy Notice. State law guarantees confidentiality between counselors and their clients. This means that whatever you tell me is private, and I make every attempt to protect information about you from possible misuse. In many cases, your written permission is required before I can release records.

However, there are a few exceptions not covered in the attached privacy notice about which you should know:

Insurance Companies. If you choose to use insurance to cover your treatment costs, you will need to sign a release giving your insurance company the right to know certain things about you. This information includes a diagnosis, type of treatment, dates, and sometimes a justification for treatment. While most insurance companies keep medical information confidential, I cannot guarantee confidentiality once information leaves this office. If the insurance company asks for more detailed information than usual, I will speak to you about it and let you decide what you want them to know. However, if you choose not to provide them with information, you may be assuming financial responsibility for treatment costs yourself.

320 W. Lanier Ave Ste #200
Phone: 770-309-5891
Fax:770-309-5891

Evaluations. If you see me for a psychological evaluation at the request of another professional, it is customary to give that professional a report of the findings. Physicians, attorneys, court officials, or government caseworkers are often among those who request such a report. Court-ordered evaluations must be released to the court and are not confidential. Although you may be entitled to a summary of the test findings, you may not be entitled to receive a copy of the report.

Lawsuits. You need to be aware that if you decide to sue someone for a personal injury that is the focus of your treatment, you may be signing away your right to confidentiality. The defendant may be able to gain access to your treatment records to help in their defense.

I hereby affirm that I have carefully read the provided disclosure regarding my treatment, and I willingly consent to undergo the recommended treatment outlined therein for my healthcare.

Patient Name:_____ Patient Signature:_____

Signature Date:_____

Relationship to Patient(if patient unable to sign):_____

☐ By checking this box, I agree to use electronic records and signatures and I acknowledge that I have read the disclosure above.

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Consent for Electronic Communication Telehealth

I agree to telepsychiatry services and electronic messaging with my provider. I understand that my phone company may charge me for messaging and that is my responsibility. I understand that I am responsible for ensuring the security of personal health information messaging received by email, phone, voicemail, message, or telehealth services. I am opting into both phone messaging, and telehealth visits. I will tell my provider if at any time I choose to opt-out of these services.

Telehealth Visits: I understand that I must be available at the time of my telehealth visit or my appointment will be canceled within 15 minutes of my scheduled time and will have to be rescheduled and it will be documented as a no-show.

☐ **I would like to opt in for telehealth service options with my email I provide the office.**

☐ **I would like my appointment reminders delivered by text to the phone number on file.**

☐ **I agree to communication via the patient portal delivered by text or email on file**

☐ **I agree to have homework delivered to my email address on file**

Patient Name:_____ Patient Signature:_____

Signature Date:_____

Relationship to Patient(if patient unable to sign):_____

☐ By checking this box, I agree to use electronic records and signatures and I acknowledge that I have read the disclosure above.

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Health Insurance Portability and Accountability Act

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third-party payers (e.g. my insurance company); - The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

Patient Name:_____ Patient Signature:_____

Signature Date:_____

Relationship to Patient(if patient unable to sign):_____

☐ By checking this box, I agree to use electronic records and signatures and I acknowledge that I have read the disclosure above.

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Medical Release of Information

I authorize the release of my medical information to TelevateComp Care for the purpose of facilitating and coordinating my healthcare. This authorization includes the disclosure of all medical records, test results, diagnoses, treatment plans, and any other pertinent information related to my health. I understand that this information may be used for the purpose of continuity of care, consultations, and any necessary medical interventions.

I acknowledge that this authorization is voluntary, and I have the right to revoke it at any time, except to the extent that action has already been taken in reliance on this authorization.

I also understand that the recipient of this information is bound by confidentiality and privacy laws and will only use the disclosed information for the specified purpose.

By signing below, I confirm that I have read and understood the terms of this release and voluntarily consent to the disclosure of my medical information.

Patient Name:_____ Patient Signature:_____

Patient DOB:_____ Signature Date:_____

Relationship to Patient(if patient unable to sign):_____

☐ By checking this box, I agree to use electronic records and signatures and I acknowledge that I have read the disclosure above.

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Uses and Disclosures for Treatment, Payment, and Healthcare Operations

Our provider(s) may use or disclose your protected health information (PHI), for treatment, payment, and healthcare operations purposes with your consent.

To help clarify these terms, here are some definitions:

"***PHI***" refers to information in your health record that could identify you.
*"**Treatment**"* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another healthcare provider, such as your family physician or another mental health professional.
"***Payment***" is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
"***Health Care Operations***" are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
"***Use***" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
"***Disclosure***" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

I. **Uses and Disclosures Requiring Authorization**
I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures.

If I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain authorization from you before releasing this information. I will also need to obtain authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session. I keep these separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have

already acted in reliance on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

II. **Uses and Disclosures with Neither Consent nor Authorization**
I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I have reasonable cause to believe that a child has suffered abuse or neglect, I am required by law to report it to the proper law enforcement agency or the Georgia Department of Social and Health Services.

Adult and Domestic Abuse: If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, I must immediately report the abuse to the Georgia Department of Social and Health Services. If I have reason to suspect that sexual or physical assault has occurred, I must immediately report to the appropriate law enforcement agency and to the Department of Social and Health Services.

Health Oversight: If the Georgia State Department of Health subpoenas me as part of its investigations, hearings, or proceedings relating to the discipline, issuance, or denial of licensure of state-licensed mental health professionals, I must comply with its orders. This could include disclosing your relevant mental health information.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided to you and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: I may disclose your confidential mental health information to any person without authorization if I reasonably believe that disclosure will avoid or minimize an imminent danger to your health or safety, or the health or safety of any other individual.

Worker's Compensation: If you file a worker's compensation claim, with certain exceptions, I must make available, at any stage of the proceedings, all mental health information in my possession relevant to that particular injury in the opinion of the Georgia Department of Labor and

Industries, to your employer, your representative, and the Department of Labor and Industries upon request.

III. **Patient's Rights and Mental Health Professional's Duties**

Patient's Rights:

Right to Request Restrictions –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you can ask that I send bills to an address other than your home).

Right to Inspect and Copy – You have the right to inspect or obtain a copy of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. There may be a fee for copying this information. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. At your request, I will discuss with you the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization as described in Section III of this Notice. On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Mental Health Professional's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. However, unless I notify you of such changes, I am required to abide by the terms currently in effect.

IV. **Effective Date, Restrictions, and Changes to Privacy Policy**
This notice is effective January 10, 2024. I reserve the right to change the terms of this notice. and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by giving or mailing you a revised copy.

V. **Complaints**
If you are concerned that I have violated your privacy rights, or you disagree with a decision I made, I encourage you to discuss it with me directly to understand my decision and to negotiate a solution.

You may also contact the Georgia State Department of Health to discuss the matter and/or file a complaint.

Contact the Examining Board of Psychology at (360) 236-4928. For Counselors and Social Workers, this number is (360) 753-1761. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. My office will provide you with the appropriate addresses upon request.

I certify that I have given a copy of "Office Policies, Informed Consent for Treatment, and Protecting the Privacy of Your Health" to the above person.

Patient Name:_____ Patient Signature:_____

Signature Date:_____

Relationship to Patient(if patient unable to sign):_____

☐ By checking this box, I agree to use electronic records and signatures and I acknowledge that I have read the disclosure above.

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Financial Policy

At TelevateComp Care, we are committed to providing quality healthcare services through telehealth for individuals covered under workers' compensation. To ensure clarity and transparency regarding financial matters, we have outlined the following financial policy:

1. **Verification of Workers' Compensation Coverage:**
   Before scheduling or conducting any telehealth appointments, it is the responsibility of the patient to provide accurate and up-to-date workers' compensation insurance information. Our practice will verify coverage to ensure eligibility for services.

2. **Billing and Claims:**
   We will submit claims directly to the workers' compensation insurance carrier on behalf of the patient. Patients are responsible for providing any necessary information required for claim processing promptly.

3. **Authorization for Services:**
   Our office must obtain proper authorization from their workers' compensation insurance carrier before scheduling telehealth appointments. Failure to secure authorization may result in the patient 's appointment being canceled.

4. **Self-Pay Patients:**
   For patients not covered by workers' compensation insurance, a self-pay arrangement can be made. Our practice will provide transparent pricing information, and payment will be due at the time of service.

By receiving services from TelevateCompCare patients acknowledge and agree to comply with the terms outlined in this financial policy. Our practice reserves the right to update this policy as needed, and any changes will be communicated to patients in a timely manner. If you have any questions or concerns regarding this policy, please contact our billing department for clarification.

By signing below, I confirm that I have read and understood the terms of this release and voluntarily consent to the disclosure of my medical information for financial purposes.

Patient Name:_____ Patient Signature:_____

Signature Date:_____

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Office Policies

Attendance:

In-person Visits:

Our office address is 320 W. Lanier Ave. Suite 200 Fayetteville, GA 30214. We are located on the second floor of Regus Building

Please arrive 15 minutes prior to you appointment time, enter the glass doors. Someone from our office will come out to greet you

Please contact our office at 770-309-5891 if you anticipate being late.

To create a conducive and focused environment, we ask that you attend your sessions alone. Here is why this is important:

a. Privacy and Confidentiality: Therapy sessions often involve personal and sensitive discussions. By attending alone, you can freely express your thoughts and feelings without concerns about the presence of others compromising your privacy or confidentiality.

b. Undivided Attention: Therapy sessions require your full attention and focus to maximize their effectiveness. Having someone else present may distract you from fully engaging in the therapeutic process and hinder your progress.

c. Creating a Safe Space: We aim to provide a safe and supportive space for you to explore your thoughts and emotions. Limiting external influences by attending alone helps maintain this therapeutic environment.

d. Optimizing Your Progress: Our primary goal is to help you achieve your therapy goals efficiently. Attending alone allows us to concentrate on your unique needs and tailor our sessions accordingly.

Telehealth Visits:

Please open your application 15 minutes before your appointment time to allow any troubleshooting with your device.

The provider will initiate the appointment.

You must be in a private environment. You cannot conduct an appointment from a moving car where the internet is not stable.

Please turn on Do Not Disturb on your device before your appointment.

If you are not greeted with "Please wait, I will be with you shortly" and are in the waiting room for more than 2 minutes past your appointment time, call the office at 770-309-5891.

You may also text. Do not wait more than 2 minutes to call the office if you do not hear from the provider in the waiting room.

Scheduling/Rescheduling/Cancellations:

All appointment dates and times are listed in the Myio App.

Your appointment will be canceled if you are more than 15 minutes late.

Before rescheduling your appointment, our office will have to ensure authorization has been provided by your insurer.

Appointments must be rescheduled or canceled no later than 48 **business** hours before your appointment date and time.

Our office must be contacted via the patient portal or phone at 770–309–5891.

Please be advised that any appointments are rescheduled or canceled later than 48 business hours will count as a late cancellation.

Failure to attend an appointment will be documented as a no-show. This also counts towards your authorized visits.

Homework:

Homework will be delivered via email and our Myio App resource center.

There maybe requirements for these assignments to be submitted. Screenshots will be accepted.

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Authorizations:

Our office must obtain proper authorization from their workers' compensation insurance carrier before scheduling telehealth appointments.

Failure to secure authorization may result in your appointment being canceled.

Please be advised that no-shows and late rescheduled appointments count towards visits that are authorized by the workers' compensation carrier.

Patient Responsibilities:

Patient must download Myio app for patient portal access and appointments.

Patient must provide our office an updated phone number and email address.

Patient must inform the treating provider of all medications, including over-the-counter drugs and supplements.

Medication adjustments will only be made in consultation with the treating provider.

Patients are expected to actively participate in their treatment plan.

Non-compliance with the treatment plan may impact the effectiveness of care.

Respectful and non-disruptive behavior is expected from all patients.

Any threats or violent behavior will result in immediate termination of services.

TelevateComp Care reserves the right to discharge patients for non-compliance, disruptive behavior, or failure to meet financial obligations.

Patients have the right to terminate services with reasonable notice.

By signing below, I confirm that I have read and understood TelevateComp Care's office policies.

Patient Name:_____ Patient Signature:_____

Signature Date:_____

☐ By checking this box, I agree to use electronic records and signatures and I acknowledge that I have read the disclosure above.

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Consent for Electronic Communication

I consent to receive communication reminders via text message, email, and phone calls from TelevateComp Care for the purpose of appointment reminders, health-related information, and other relevant communications.

Communication Channels:

1. Text Messages:
   - I understand that standard text messaging rates may apply.
   - I acknowledge that text messages may be sent using an automated system.
   - I agree to receive appointment reminders and other health-related information via text message.

2. Email:
   - I consent to receiving communication reminders and health-related information via email.
   - I understand that emails may contain sensitive health information and will be treated with confidentiality.

3. Phone Calls:
   - I authorize phone calls to the provided contact number for appointment reminders and health-related communication.
   - I understand that automated systems may be used for phone call reminders.

Patient Name:_____ Patient Signature:_____

Signature Date:_____

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