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Informed Consent for Counseling and Psychotherapy

Mental Health Services

Ethos Clinics recognizes that it may not be easy to seek help from a mental health professional; we hope that with our help you will be better able to understand your situation and feelings and will be able to move towards resolving your difficulties. The therapist will strive to *assist* you grow towards greater health and wholeness by providing counseling services within a biopsychosocial, cognitive-behavioral perspective. Our therapist works within the context of each individual's beliefs, and no attempt is made to impose personal theology.

Therapist

The therapist is a trained professional engaged in providing mental health care services to clients directly as an employee of Ethos Clinics. The therapist has discussed with me the various aspects of psychotherapy. This includes a discussion of the evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. You may withdraw from treatment at any time, but please discuss this with your therapist.

Appointments and Cancellations

Appointments are made by calling the office location most convenient for you (Lehighton: 610-900-4234, Bethlehem: 610-625-1486, Emmaus: 484-232-5288), Monday through Friday, between the hours of 9:00am and 5:00pm. If you are unable to get through when you call please leave a message with your name, purpose of your call, and a call back number and a staff member will get back to you within 72 hours. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment and the absence will be marked on your record. Third-party payments will not usually cover reimburse for missed appointments. Medicaid clients are not charged a fee per the law, but will be held accountable to the office No Show and Cancellation Policy (See the No Show and Cancellation Policy form). Your therapist reserves the right to cancel your appointment if you show up sick, late, or with minor children that might interfere with the counseling session.

Number and Length of Sessions

The number of sessions needed depends on many factors and will be discussed by the therapist. The length of therapy sessions range depending on several factors and the therapist will discuss this with you as well.

Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social and personal relationship with you. Gifts, bartering and trading services are not appropriate and should be shared between you and the therapist.

Goals, Purposes, and Techniques of Therapy

There may be multiple interventions to effectively treat the problems that you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the

therapist and to have input in setting goals of your therapy. As therapy progresses, these goals may change.

Confidentiality
Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases, suits in which the mental health of a party is is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with a licensing board or other state or federal regulatory authority.

If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing the Receipt form for the Informed Consent and Privacy Practices, you are giving consent to the therapist to share confidential information with all persons mandated by law, with the agency that referred you, and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services. You are also releasing and holding harmless the therapist from any departure from your right to confidentiality that may result.

Duty to Warn
In the event that the therapist reasonably believes that the client is in danger, physically or emotionally, to themselves or another person, consent is given for the therapist to warn the person in danger and to contact any person in a position to prevent harm to themselves or another person, including law enforcement and medical personnel. This authorization shall expire upon the termination of therapy.

By signing Informed Consent and Privacy Practices form, you acknowledged that you have the right to revoke this authorization in writing at any time to the extent the therapist has not taken action in reliance on this observation. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the Notice of Privacy Practices section of this form. You acknowledge that you have been advised by the therapist of the potential of the re-disclosure of your protected health information by authorizing recipients, and that it will no longer be protected by the federal Privacy Rule. You further acknowledge that the treatment provided to you by the therapist was conditioned on you providing this authorization.

Risks of Therapy
Therapy is the Greek word for *change*. Clients often learn things about themselves that they don't like. Often growth cannot occur until past issues are experienced and confronted, often causing distressing feelings such as sadness and anxiety. The success of therapy depends upon the quality of the efforts of both the therapist and client, along with the reality that clients are responsible for the lifestyle choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce option.

Payment for Services

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If you have insurance, different copayments are required by various group coverage plans. Your copayment is based on Mental Health Policy selected by your employer or purchased by you. You are responsible for and shall pay your copay portion of therapist's charges for services at the time services are provided. You are responsible for notifying Ethos Clinic immediately of any changes to your insurance. If you fail to notify Ethos Clinic of any changes to insurance, you may be billed for services that are not covered. **Ethos will look to you for full payment of your account, and you will be responsible for payment of all charges.**

Court

Although it is the goal of the therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by the law. In the event disclosure of your records or therapist's testimony are requested by you or required by law, you will be responsible for and shall pay the costs involved in producing the records and the therapist's normal hourly rate for giving that testimony. Such payments are to be made prior to the time the services are rendered by the therapist. The therapist may require deposit for anticipated court appearances and preparation.

After-Hour Emergencies

Emergencies are defined as urgent issues requiring immediate action. **If you are experiencing a psychiatric or medical emergency and reach the business after hours, call or report to your local emergency room immediately.** Other national resources include, but are not limited to: Suicide Prevention Hotline, 1-800-273-8255 ;MH Warm Line, (866) 854-8114 ;Suicide Prevention Text Services: text 741741; ;

Therapist's Incapacity or Death

In the event the therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of client records. By signing Informed Consent and Privacy Practices Receipt, you give consent to another licensed mental health professional at Ethos Clinic to take possession of your files and records and provide you with copies upon request, or to deliver them to a therapist of your choice.

Consent to Treatment

By signing Informed Consent and Privacy Practices Receipt, you voluntarily agree to receive mental health assessment, care, treatment or services and authorize the therapist 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. By signing the informed Consent and Privacy Practices Receipt, you acknowledge that you have both read and understood all the terms and information contained herein. Ample opportunity has been offered for you to ask questions and seek clarification of anything that remains unclear.

Contact Information

By signing the Informed Consent and Privacy Practices Receipt, You are consenting for Ethos Clinic to communicate with you by mail, e-mail, and phone at the address and numbers provided at the initial appointment, and you will immediately advise Ethos Clinic in the event of any change. You agree to notify the Center if you need to opt out of any form of communication.

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General Consent for Care and Medical Treatment

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Client Name Print _____ DOB:_____

Client Signature:_____ Date:_____

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable
federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact your doctor if you have any other questions about privacy practices.

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HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- The practice may utilized Surescripts to assist in the continue of care for medication management.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____

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HIPAA Contact Release Form

In order for us to stay within guidelines of HIPAA, please list below any person/persons that you authorize us to disclose information to regarding you Protect Health Information, including billing information.

	Name	Relationship	Phone
1			
2			
3			
4			

I understand that I may rescind permission at any time by notifying the office.

Patient's Name (Please Print) Date of Birth

Patient's Signature (or Guardian) Date

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Ethos Clinics

Duty of Payment

I, _____, have requested Ethos Clinics to bill my insurance on my behalf for payment of services. I clearly understand that it is my responsibility to be financially responsible for services rendered.

This is including but not limited to; insurance adjustments, denied claims, or services not covered by my plan. If there is a balance owed on my account, I agree to make arrangements for prompt payment.

I understand if my benefits or coverage should change while I am receiving treatment, I must notify Ethos Clinics immediately in order for proper insurance claims information to be submitted on my behalf.

Furthermore, if my insurance company does not pay the provider directly, I agree to relinquish payment to Ethos Clinics upon receipt of the check.

My signature indicates that I have read and understand the policy above.

Print Name of Patient:_____ **Signature:**_____

Print Name of Policy Holder if Different from Patient:

_____

Signature of Policy Holder if Different from Patient:

_____

Witness:_____ **Date:**_____

Ethos Clinics

Patient Consent for Electronic Prescribing

Ethos Clinics has implemented e-prescribing as part of an on-going effort to improve your health care. It is a system used to submit prescriptions electronically to the pharmacy of your choice. E-prescribing creates a more efficient and safer process for patients to access their medication. It helps to prevent, and in some cases eliminate, the top reasons for prescription errors - including illegible handwriting, incorrect dosing, and missed drug/allergy interactions. This improves patient care and safety, and decreases medication errors.

E-prescribing systems also store and transmit your prescription information with medication history to your health care providers and insurers. This allows for information to be obtained quickly about the drugs covered under your benefit plan, as well as the drugs you may already be taking to minimize adverse drug events.

By signing below, you provide your consent for Ethos Clinics and its providers to electronically submit your prescriptions through the e-prescribing system described above. You also are also consenting for your provider to request and use your prescription medication history, from other healthcare providers and/or third party pharmacy benefit payors, for treatment purposes.

This consent will remain in effect until you withdraw it. You may withdraw at any time except to the extent it has already been relied upon. Your decision not to sign this form will not affect your ability to receive medical care, or your ability to receive your prescriptions through alternative means.

Date:_____

Print Name:_____ **Signature:**_____

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Guardian/Healthcare Proxy Print:_____

Signature:_____

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Pain Treatment with Opioid Medications: Patient Agreement*

I,_____, understand and voluntarily agree that (initial each statement after reviewing):

_____I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

_____I will participate in all other types of treatment that I am asked to participate in.

_____I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

_____I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_____I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_____I will sign a release form to let the doctor speak to all other doctors or providers that I see.

_____I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

_____I will use only one pharmacy to get all on my medicines:_____
Pharmacy name/phone#

_____I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) without telling a member of the treatment team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

*Adapted from the American Academy of Pain Medicine
http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3203

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_____I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

_____I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

_____I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

_____I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Pain Treatment Program Statement

We here at_____are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition. We

will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

Patient signature	Patient name printed	Date
Provider signature	Provider name printed	Date

*Adapted from the American Academy of Pain Medicine
http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3203

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Fax: (570) 392-6143

3835 Chestnut St.
Emmaus, PA 18049

Phone: (484) 232-5288

428 South 7th St.
Lehighton, PA 18235

Phone: (610) 900 4234

Authorization To Release/Obtain Health Information

I, _____(DOB:_____), hereby authorize_____to release/obtain information from Medical records pertinent to the Mental Health/Mental Retardation; Drug/Alcohol treatment; and or HIV/AIDS treatment of: _____.

(Individual's Name)

ROI Valid from _____ until _____, or one year from date signed.

_____

(Name of Person/Organization/Facility obtaining records from)

_____

(Address)

The information which may be released is limited to the MOST RECENT:

_____ Discharge Summary

_____ Psychiatric Assessment

_____ Medication Log

_____ Blood work

_____ Other

_____

The purpose or need for such disclosure is:_____

Behavioral Health services may not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign authorization except if my treatment is related to research or if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Hereby release Behavioral Health Services and all other persons or legal entities of facilities, related in any way to the release of said information from all responsibility and liability for acting upon this authorization and I intend to be legally bound hereby.

Individual, Parent, Legal Guardian Signature_____**Date**_____

Personal Representative Signature _____**Date**_____

Witness/Staff Member Signature _____**Date**_____

If any person physically unable to provide a signature desires to consent to this release, print his/her dame on the appropriate signature line above and record below the signature of two responsible persons who witness that such a person understand the nature of this release and freely gave his/her consent.

Witness Signature _____**Date**_____

Witness Signature _____**Date**_____

EXAMPLE

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Ethos Clinic

3835 Chestnut St.

Emmaus, PA 18049

Phone: (484) 232-5288 Fax: (570) 392-6143

Authorization To Release/Obtain Health Information

I, **PATIENT NAME** (DOB:**PATIENT BIRTHDAY**), hereby authorize **ETHOS** to release/obtain information from Medical records pertinent to the Mental Health/Mental Retardation; Drug/Alcohol treatment; and or HIV/AIDS treatment of: **PATIENT NAME**.

(Individual's Name)

ROI Valid from **TODAYS DATE** until **TODAY's DATE NEXT YEAR**, or one year from date signed.

OUTSIDE ENTITY NAME **OUTSIDE ENTITY PHONE #** **OUTSIDE ENTITY FAX #**

(Name of Person/Organization/Facility obtaining records from)

OUTSIDE ENTITY FULL ADDRESS

(Address)

The information which may be released is limited to the MOST RECENT:

_____ **Discharge Summary** _____ **Blood work**

_____ **Psychiatric Assessment** __X__ **Other**

_____ **Medication Log** _____

The purpose or need for such disclosure is: COORDINATION OF CARE or CONTINUITY OF CARE
Behavioral Health services may not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign authorization except if my treatment is related to research or if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Hereby release Behavioral Health Services and all other persons or legal entities of facilities, related in any way to the release of said information from all responsibility and liability for acting upon this authorization and I intend to be legally bound hereby.

Individual, Parent, Legal Guardian Signature: AGE 14+ PATIENT SIGNATURE Date DATE

Personal Representative Signature 0-13= LEGAL GUARDIAN SIGNATURE or POA if applicable Date DATE

Witness/Staff Member Signature _____ **Date** _____

If any person physically unable to provide a signature desires to consent to this release, print his/her dame on the appropriate signature line above and record below the signature of two responsible persons who witness that such a person understand the nature of this release and freely gave his/her consent.

Witness Signature _____ **Date** _____

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Missed Appointment Policy

In order to provide the best service to our patients, we have established the following policy.

If you miss an appointment, there will be a $30.00 no-show fee. This fee is to be paid at your next scheduled visit. You will receive a phone call a few business days after the missed appointment, if you do not call to reschedule.

Two no-shows and/or late cancellations with less than 24 hours notice, within a calendar year, will result in discharge from the practice. Very often there are understandable and unavoidable reasons for missing appointments, however, a missed appointment prevents another patient from receiving services. This has a significant impact on our practice and the care we provide. Our policy is to best service you.

My signature indicates that I have read and understand the policy above.

Print Name:_____ Date:_____

Signature:_____

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Ethos Clinic ADHD Policy

Please be advised that Ethos Clinic will not be accepting new adult ADHD patients ***unless*** the patient is able to provide a recent neuropsychological evaluation that demonstrates this diagnosis. In order to obtain a neuropsychological evaluation you can call the member services number on the back of your insurance card and ask what providers may be in network. If your insurance requires a referral for this type of evaluation we urge the patient to reach out to their PCP, in order to complete appropriate neuropsychological testing prior to starting treatment at Ethos Clinic.

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Ethos Clinic
4379 Easton Ave
Suite 101
Bethlehem, PA 18020
P: 610- 625-1486
F: 570-392-6143

Medication Policy:

Please call with medication refill concerns *at least 1 week prior* to completion of current prescription, in order to prevent gaps in medication. Refill requests will be processed within *2 business* days (48 hour period), of when request is received (i.e. if request is given after business hours, on a weekend, or a holiday the office will address this concern when it is received on the next scheduled business day).

Kindest Regards,

Ethos Clinic

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4379 Easton Ave. Ste 101
Bethlehem PA 18020
P: (610) 625-1486
F: (570) 392-6143

Paperwork/Forms Policy:

Please be advised that no Time Off, FMLA, or Disability paperwork/forms will be filled out for patients who are not established with the practice. To be established with the practice the patient must have been seen by one Ethos Clinic physician for a minimum of 2 consecutive visits. From the 3rd visit on, it is at the *provider's discretion*, to assist with the above mentioned paperwork based on medical necessity. Providers require 10-14 business days in order to complete any documents.

Additionally, a completion fee of $25 for short documents and $75 for long documents will be charged in order to account for the time required for providers to complete the paperwork.

Kindest Regards,

Ethos Clinic