Informed Consent for Treatment (medication management and counseling) 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, 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 reimbursements 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, intoxicated, 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 not 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. By signing consent you understand that you are not to show up to therapy or medication management appointments under the influence of drugs or alcohol. If you appear intoxicated, your session will be canceled and necessary steps will be taken to make sure you can leave the office safely.

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

If you have insurance, different copayments are required by various group coverage plans. Your copayment is based on a 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**;** https://suicidepreventionlifeline.org/ ; http://www.yourlifeyourvoice.org

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. I hereby give consent Ethos is going to document my visit using artificial intelligence software DeepScribe.

Telehealth Services

By signing the Informed Consent and Privacy Practices Receipt, you are consenting to the understanding of the use of HIPAA compliant audio/video technology. You understand that you are expected to be in a private and secure location for your telehealth appointment as will the therapist and provider on their end. You understand the risks associated with telehealth services and agree to have a session via telehealth when it is appropriate.

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 Clinic if you need to opt out of any form of communication.

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:_____

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 3 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 to complete any documents.

Additionally, a **completion fee** of anywhere between **$25** for shorter documents to **$200** for longer documents will be charged to your account based upon the nature of the document and time it may take your provider to complete.

Kindest Regards,

Ethos Clinic

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

Print Name:_____ **Date:**_____

Signature:_____

Medication Policy:

Please call with medication refill concerns at least 1 week prior to completion of current prescription, to prevent gaps in medication. Refill requests will be processed within 2 business days (48-hour period) of when the 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

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

Print Name:_____ **Date:**_____

Signature:_____

Missed Appointment Policy

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

Definitions:

- **No-Show:** not showing for a scheduled appointment without prior notice.
- **Late Cancel:** canceling an appointment with less than 24 hour notice (this is also considered a No-Show for attendance purposes).
- **Cancel:** canceling an appointment with more than 24 hours notice.

Initial Appointments:

- If you **No-Show** your intake appointment, you will not be eligible for rescheduling.

Ketamine Appointments:

- Because this is an elected treatment any no shows will be charged **$100** that will need to be paid before continuing.

Ongoing Appointments:

- Two **No-Shows** and/or **Late Cancellations** with less than 24 hours notice for therapy,within a calendar year, will result in **being discharged from therapy.**
- Two **No-Shows** and/or **Late Cancellations** with less than 24 hours notice, within a calendar year, for the medication management provider will be grounds for case review and potential discharge from Ethos Clinic.

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. **If you No-Show or Late Cancel an appointment, there will be a no-show fee ranging from $60- $100**. **This fee is to be paid before scheduling any further appointments**. **We do our best to send out reminders but please note these are a courtesy, it is the patient's responsibility to keep track of all appointments. 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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Patient Medication Agreement

I, _____, have reviewed, understand and voluntarily agree with the following statements:

- ☐ I will keep (and be on time for) all of my scheduled appointments (that will be scheduled at least every 3 months) 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 medication safe, secure, and out of the reach of children. If my medication is lost or stolen, I understand that it will not be replaced until my next appointment or may not be replaced at all. ☐ I will take medication as instructed and not change the way that I take it without first talking to the doctor or other member of the treatment team.
- ☐ I understand that prescriptions will be filled during scheduled office visits with the treatment team and have reviewed the refill policy.
- ☐ I will make sure that 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 respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment may be stopped.
- ☐ I will not sell my medications or share them with others. I understand that if I do, my treatment will be stopped.
- ☐ I will sign a release form to let my 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 medication.
- ☐ I will tell the doctor or a treatment team member immediately if I am pregnant or planning to become pregnant.
- ☐ I will not get any opioid pain medications or other controlled medicines that can be addictive such as benzodiazepines (xanax, klonopin, 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.
- ☐ I will use only one pharmacy to get all of my prescriptions: _____Pharmacy Name/ Phone #
- ☐ I will not use illegal drugs such as heroin, cocaine, marijuana (illicit not MMJ if prescribed to me) or amphetamines. I understand that if I do, my treatment may be stopped.
- ☐ If necessary for my individual treatment 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.

PRINTED NAME_____PATIENT SIGNATURE_____DATE_____

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 the 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.

PRINTED NAME_____**PATIENT SIGNATURE**_____**DATE**_____

Duty Of Payment

I _____, have requested Ethos Clinic to bill my insurance on 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 adjustment, 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 Clinic immediately in order for proper insurance claims information to be submitted on my behalf.

Furthermore, if my insurance company doesn't pay the provider directly, I agree to relinquish payment to Ethos Clinic upon receipt of the check.

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

PRINTED NAME_____PATIENT SIGNATURE_____DATE_____

Signature of policy holder if different from patient:

PRINTED NAME_____SIGNATURE_____DATE_____

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 your 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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Authorization To Release/Obtain Health Information

I, _____(DOB:_____), hereby authorize **ETHOS CLINIC** 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

_____

(Address)

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

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

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

_____**Medication Log** _____

The purpose or need for such disclosure is: 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 enes 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**_____

GENERAL FAX: 570-392-6143//LEHIGHTON PHONE:610-900-4234//EMMAUS PHONE:484-232-5288

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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 unl 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 enes 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 Representave 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**_____

Telehealth Consents

1. Telehealth services include video and phone sessions and can be delivered by the medication provider, nurse or therapist.
2. The patient will be in a private location, preventing interruptions and distractions such as children or other family members and visitors in the household.
3. The patient will not be driving during their session and make sure they are in a safe location. If the staff person feels that you are not in a safe or appropriate location for the session it will be cancelled and you could be charged a no show fee.
4. **Patients will have to be in the state of Pennsylvania during the session unless the clinician is licensed in the state the patient is currently located, i.e., patients on vacation. Please note if you are out of state this is considered a NO SHOW and you will be charged a fee.**
5. When telehealth is being used to deliver services to an individual who is at a clinic, group home, or other types of facility settings, the originating site must have staff trained in telehealth equipment and protocols to provide operating support.
6. Telehealth services will only be provided if it is clinically appropriate and a patient is unable to come into the office due to physical, mental or logistical limitations such as lack of transportation.
7. When the use of telehealth is not clinically appropriate you will be offered the services in-person. If you disagree, staff will refer you to other in-network providers.
8. Services being delivered through telehealth to:

a. Children 3 to 9 years old, each child should have a caregiver participate during the provision of services unless otherwise noted not necessary at the time.
b. Children ages 10 to 13 years old, any child that may need a caregiver during the provision of services should have a caregiver available.
c. Youth 14 years old to 18 years old, any youth that may need a caregiver during the provision of services should have a caregiver available.
d. All children or youth that participate in services through telehealth delivery should have the ability to communicate, either independently or with accommodation such as an interpreter or electronic communication device.

9. In the event of technical difficulties during a video session, staff will attempt to complete a session via audio or reschedule the session as soon as possible.
10. In the event of a clinical emergency during a telehealth session:
    a. Staff will utilize de-escalation techniques and/or refer back to the patient's Suicide Management Plan
    b. Staff will inquire if the patient has a support person available with them.
    c. Staff will call 911 if the patient is presenting as a danger to themselves or someone else.

Weekend Appointment Policy

- Patients must call the office and cancel and/or reschedule their appointment 24 hours prior to scheduled appointment.

- Weekend Appointments (Saturday and Sunday) must be cancelled by the end of business day Thursday.

- First No Show for a weekend appointment will result in the patient no longer being offered this option and will need to be scheduled during the week.

- Calling on the weekend and leaving a message to cancel their Monday appointment is **NOT** 24 hours notice and the patient will be charged the no-show fee.

- Patients who do not arrive for their scheduled appointment cancel and/or reschedule their appointment 24 hours prior will be charged a $100.00 no-show fee.
- The no-show fee is to be paid at the next scheduled appointment.

- Patients will receive a phone call a few business days after the missed appointment, if they do not call to reschedule.

- The first 2 No show/late cancellations within a 6 month time period patient will be suspended from services and can restart services 6 months later. However, 2 no show/late cancellations in the following 6 month time period the patient will be discharged from therapy.

- First no show/late cancellation for medication management will allow for one refill to be issued until the next scheduled appointment. 2nd no show/late cancellation will not permit for refills until the patient attends their next appointment. 3rd no show/late cancellation will result in being discharged from the practice.

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:_____

Guardian Name Print: _____Relation:_____

DOB:_____Social Security Number:_____

Guardian Signature:_____Date:_____

Guardian Name Print: _____Relation:_____

DOB:_____Social Security Number:_____

Guardian Signature:_____ Date:_____

Intent of Treatment waiver

By signing this Document I acknowledge that any evaluation, assessment, therapy or medication management is for the treatment of the client as an individual, and *is not* to be used for the purpose of determining parental competency or custody. Such an evaluation should be conducted by an independent evaluator designed for that specific purpose.

Client Printed Name:_____DOB:_____

Client Signature:_____Date:_____

Guardian Printed Name:_____Relation:_____

Guardian Signature: _____Date:_____

Guardian Printed Name:_____Relation:_____

Guardian Signature: _____Date:_____