This agreement is an Authorization to Treatment between the client (signature below) and Dr. Melanie Bliss located at 111 N. McDonough St., Decatur, GA 30030, phone number 404-387-0780; Business name is Melanie Joy Bliss, LLC.

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is available on my website ("Georgia Notice Form"), explains HIPAA and its application to your personal health information in greater detail.

Although these documents are long and sometimes complex, it is important that you read them carefully. We can discuss any questions you have. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES:

The content areas included in psychological services are broad and may include consultation, evaluation, and/or treatment. Consultation involves my giving you information, opinions and/or advice in a general or specific sense about areas of psychological problems. Evaluation involves my conducting an assessment of you and others in order to render a professional opinion, including child custody evaluations. Treatment involves my rendering intervention services to assist you and others with psychological problems and may include psychotherapy as well as other forms of treatment. There are no guarantees that any of these psychological services will be successful. The outcome of them usually involves collaboration between us.

If you have questions about any of my procedures, we should discuss them whenever they arise. If you believe it to be helpful, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

thrive
CENTER FOR PSYCHOLOGICAL HEALTH, LLC

MEETINGS:

1. Appointments are typically scheduled for 45-50 minutes.
2. During the first one to two sessions, I will conduct a psychological evaluation/intake to help determine your best treatment options. This evaluation may involve psychological testing.
3. **Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.**

PROFESSIONAL FEES, BILLING, AND PAYMENT: Please see Fee Schedule/Business Policies form. Your signature on this form and to the Fee Schedule/Business Policies form acknowledges that you understand you are responsible for my full fee and all fees indicated on that form.

INSURANCE REIMBURSEMENT:

1. If you have a health benefits policy, it may provide some coverage for mental health treatment. I will provide you with whatever assistance I can in facilitating your receipt of the benefits to which you are entitled. You, not your insurance company, are responsible for full payment of fees to which we have agreed; therefore, it is very important that you find out exactly what mental health services your insurance policy covers.
2. You should carefully read the section in your insurance coverage booklet that describes mental health services. Many companies only authorize a limited number of sessions in a limited amount of time. If you have questions, you should call your plan and inquire. I will provide you with whatever information I can and will be happy to try to assist you in deciphering the information you receive from your carrier. I am "out of network," in which case you will pay my full fee and submit a claim to your insurance company that I will provide to you. If you have "out of network" benefits than your insurance will reimburse you for a portion of the session based on your out of network benefits.
3. Please note I have "Opted Out" of Medicare Plans. If you would like to receive services here, Medicare requires that you acknowledge the following:
    1. You are accepting full responsibility for the payment of my charges for all services.
    2. You understand Medicare has limits on charges that do not apply to what I may charge as an opted out provider.
    3. You agree not to submit a claim to Medicare or ask me to submit a claim to Medicare for these services.

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4. You understand that Medicare payment will not be made for any items or services furnished by me that would otherwise have been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted
5. You are entering into this contract with the knowledge that you have the right to obtain Medicare-covered services from providers who have not opted-out from Medicare, and that you are not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other providers who have not opted out.
6. You are aware that my opted out status will be effective for at least 2 years, and that this status will automatically renew at expiration.
7. You understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid by Medicare.

Your signature at the bottom of this form acknowledges the above and to acknowledges your desire to enter into a private contract for payment.

4. Insurance agreements require you to authorize me to provide a clinical diagnosis. At times, additional clinical information such as a treatment plan, summary, or a copy of the entire record is required before payments are made or additional sessions are authorized. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.
5. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by contract.

CONTACTING ME:

1. I am often not immediately available by telephone. For non-emergencies, I will make every effort to return your call as soon as possible. The hours that I am in the office vary and I am not available to answer phone when I am with a client. When I am unavailable,

please leave me a voice mail message, which I check regularly, and please leave times when you will be available.

2. **If it is an emergency** and you feel that you cannot wait for me to return your call, you do not reach me, or I do not return your call in a manner suitable to your needs, you should call 911, your family physician, or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call. If I am unavailable for an extended time, I will provide on my voicemail the name of a trusted colleague whom you may contact if necessary.

LIMITS ON CONFIDENTIALITY:

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

1. I may occasionally find it helpful to consult other professionals about a case, including the other therapists of Thrive Center for Psychological Health. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note consultations in your Clinical Record.
2. I currently do not employ administrative staff. If this situation changes, I will notify you in writing with a revised consent for you to sign. All mental health professionals are bound by the same rules of confidentiality.
3. Disclosures may be required by health insurers or to collect overdue fees.
4. Confidential information regarding payments may be revealed to third party vendors that provide business and accounting services to my practice, including Lyra Bookkeeping and Payroll, Fulton & Kozak Certified Public Accountants, and Blue Stone Payments (credit card processing).
5. If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection, and I reserve the right to do so.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

1. If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions if I believe it is necessary to attempt to protect others from harm. In this case, I may have to reveal some information about a patient's treatment.

1. If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Resources (Department of Family and Children Services). Once such a report is filed, I may be required to provide additional information. In addition, the Georgia Child Endangerment Law requires that I report to the appropriate governmental agency, usually the Department of Human Resources (Department of Family and Children Services) if I am made aware of a child witnessing acts of violence between adults.
2. If I have reasonable cause to believe that a disabled adult (of any age) or elder person (over 65 years) has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
3. If I determine that a patient presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

CONSENT FOR TELEHEALTH CONSULTATION:

Your consent to this document indicates that you understand the following:

1. One or both of us may wish for us to engage in a telehealth consultation, which may include video conferencing, phone calls, texting, or any other medium through which technology is used.
2. Video conferencing technology used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that we will not be in the same room.
3. Telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of your choosing
4. To engage in telehealth you must be in the state of Georgia or in a state that is part of PsyPact (Psychology Interjurisdictional Compact).
5. There are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. Either of us can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
6. We will talk about telehealth should it become relevant, during which you will have the opportunity to ask questions in regard to this procedure.
7. SimplePractice is the technology service I use to conduct telehealth videoconferencing appointments. SimplePractice is NOT an emergency service and in the event of an emergency you must make every effort to contact me at my phone number and 911. Though we may be in direct, virtual contact through this Telehealth Service (SimplePractice), neither SimplePractice nor any telehealth service provides any medical or healthcare services, care, or advice, including, but not limited to, emergency or urgent medical services.
8. As the provider, I do not have access to any or all of the technical information in the telehealth by SimplePractice service, or that such information is current, accurate, or up-to-date. You cannot rely on me to have any of this information.
9. To maintain confidentiality, you cannot share your telehealth appointment link with anyone unauthorized to attend the appointment.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. You may examine and/or receive a copy of your Clinical Record if you request it in writing, except in unusual circumstances that involve 1) danger to yourself and others, 2) that make reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person or 3) where information has been supplied to me confidentially by others. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For

this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee of $1.00 per page (and for certain other expenses). If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others), which I will discuss with you upon request.

REQUEST FOR CONFIDENTIAL HANDLING OF HEALTH INFORMATION

All reasonable requests to receive communication of your health information will be granted (i.e., telephone, mail). **If you wish to receive protected health information in one particular manner, please indicate that to me in writing.** Otherwise, I will leave messages at the phone numbers you provide and send mail to the mailing address you have indicated. **If there is an alternative mailing address that you would like to use (for example, some people prefer that I send mail ONLY to a P.O. box or to their work address), or a specific phone number that you want me to use, than please indicate that as well.** Otherwise, your signature below indicates that I may notify you at any of the phone numbers and/or addresses that you have provided.

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychological services is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents

with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

YOUR SIGNATURE BELOW INDICATES THAT:

1. You have read, understood and agree to the terms in this document
2. You acknowledge that you have received the HIPAA "Georgia Notice Form" (see website for copy).

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