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| **Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Northern Virginia CAMP Health Services  6715 Little River Tpke, Ste 205, Annandale, VA. (571) 278-6037 |
| Address:  Do you have Medicaid/state insurance or commercial insurance/private insurance?  Yes……… No……….  Is this appointment for medication management?  Yes…….. No…… |

**To All Patients**

This appointment is because you have a mental health condition and symptoms that are currently affecting you. I am here to guide you along the way. Your responsibility is to ensure all aspects of guidance and recommendations, including medications, are followed. Also, it is your responsibility to keep all appointments.

Signature of client/parent/legal guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Missed or Canceled Appointments:**

Please notify me a week in advance if you need to cancel or reschedule your appointment. Insurance companies cannot be billed, and will not pay, for missed or late-cancelled appointments. Unless you give **me 48-hours notice**, and without exception, missed or canceled appointments will incur the usual **charge of $50**. Appointment cancellations are accepted via call and or text.

Initial \_\_

**Attention! If you are unable to connect within 10 minutes of your telehealth appointment, please call me at 240-607-5319 to discuss. Appointment will be considered NO SHOW if no show and or a call within 10 minutes of your appointment time on the telehealth platform.**

Initial \_\_

**Termination**

While the general rule is not to terminate a relationship with a patient who is not in stable condition, sometimes it is necessary when the patient fails to show up for completion of treatment. Failure to keep appointments without proper notification for 2 times will lead to termination of service. Initial \_\_

**Copay**

At your discretion, your initial appointment will be scheduled before I contact your insurance company. You are responsible for your copay and deductible at time of your appointment. Initial \_\_

**Telephone Calls and Emails**

I return calls and emails within 24 to 48 hours. If your situation is an emergency, please make that clear on your message and I will return your call as soon as possible. In an immediate crisis or emergency, call 911 or go to the nearest hospital. Your messages are picked up on my confidential voice mail and emails. It helps to leave me your phone number (even though I have it) and to let me know until what time at night I can get back to you.

Signature of client/parent/legal guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Payments**

BY PROVIDING MY CREDIT CARD INFORMATION AND RECEIVING TELEHEALTH SERVICES, I (I) AUTHORIZE WE WALK TOGETHER PROVIDER TO CHARGE MY CREDIT CARD FOR ANY AND ALL UNPAID AMOUNTS THAT WE WALK TOGETHER OR MY INSURER DETERMINES ARE MY RESPONSIBILITY, AND (II) AGREE TO PAY ALL AMOUNTS CHARGED PURSUANT TO THIS CONSENT AND AUTHORIZATION IN ACCORDANCE WITH THE ISSUING BANK CARDHOLDER AGREEMENT. I AGREE THAT WE WALK TOGETHER PROVIDER MAY CHARGE MY CREDIT CARD FOR SUCH AMOUNTS AT THE END OF MY TELEHEALTH VISIT, FACE TO FACE OR AT A LATER DATE

Signature of client/parent/legal guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **We Walk Together**  **Address: 1298 Bay Dale Dr #211, Arnold, MD 21012**  **Telephone: 240-607-5319**  **Email:** [wewalktogetherllc@gmail.com](mailto:wewalktogetherllc@gmail.com)  **Provider: Binta Bojang, PMHNP** |
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Telemental Health Informed Consent

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to participate in telemental health with, Dr. Binta Bojang as part of my medication management visit. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations

I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. 2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within 5 minutes, please call me at 240-607-5319 to discuss since we may have to re-schedule.

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Control Substance**

I agree to the following:

I am responsible for my medicines.

I will not share, sell, or trade my medicine.

I will not take anyone else’s controlled medication without prescription.

I will not increase my medicine until I speak with my doctor or nurse.

My medicine will not be replaced if it is lost, stolen, or used up sooner than prescribed.

I will keep all appointments set up by my provider.

I agree to give a blood or urine sample, if asked, to test for drug use.

Signature of client/parent/legal guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Informed Consent**

TO THE PATIENT: 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 provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care 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 the 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.

Signature of client/parent/legal guardian \_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**HIPAA Compliance 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, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

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 practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions, 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.

* May we phone, email, or send a text to you to confirm appointments?  YES or NO
* May we leave a message on your answering machine at home or on your cell phone? YES or NO
* May we discuss your medical condition with any member of your family?  YES or NO

If YES, please name the members allowed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client/parent/legal guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_