CONSENT FOR TREATMENT

I consent to receive mental health services in the form of outpatient care for myself and/or my child from Synchrony Behavioral Health Services LLC. My decision is voluntary, and I consent to receiving services under Synchrony Behavioral Health Services LLC can be terminated at any time, unless mandated by a court of law.

Nature of Mental Health Services

It's important to understand that during treatment, you may need to discuss material of an upsetting nature to address sensitive concerns. It's also important to keep in mind that there's no guarantee that you will feel better after the completion of treatment. I have been informed that, as with all healthcare treatments, results are not guaranteed and there is no promise of a cure. However, with dedication and effort, therapy and/or medication management can be an incredibly helpful tool in addressing your concerns.

Compliance with Treatment

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Therefore, frequent “no shows” and/or late cancellations or failure to follow my treatment plan in any form may be grounds for the termination of services.

Supervision

I understand there are certain circumstances which Synchrony Behavioral Health Services LLC may require supervision. There circumstances include, but are not limited to the following:

1. State licensure regulations may require my therapist or service provider to receive ongoing supervision.
2. Accreditation organizations, as well as insurance companies, may require that my treatment plan be reviewed.
3. The standards of care which guide most mental health professionals recommend that supervision and/or consultation be obtained in high-risk situations such as threats and/or acts of harm to self or others.
4. Other special circumstances, such as preparation to testify in court.

Client Rights

- The right to be treated with dignity and respect by all staff
- The right to be involved in planning and/or revision of my treatment plan
- The right to know about my treatment progress or lack thereof.
- The right to reject the use of any therapeutic technique and to ask questions at any time about the methods used
- The right to be spoken to in language that is fully understood
- The right to a clean and safe environment
- The right to refuse to be videotaped, audio recorded, or photographed
- The right to end treatment at any time unless court ordered
- The right to file a complaint or grievances about the agency or staff
- The right to confidentiality of clinical records and personal information according to federal and state laws

Emergencies

I understand that I may reach Synchrony Behavioral Health Services LLC 667-382-8624. If no one is available, a message can be left on the confidential voicemail or text message. All voicemail messages will be returned by the next business day. Synchrony Behavioral Health Services LLC is not an Emergency Service.

In the event of an emergency or urgent medical issue, I will call 911, go to the emergency department, or go to an urgent care.

I have read, discussed, and understood all of the above.

_______________________________   _________________________________

Signature/Date   Witness/Date

LIMITS OF CONFIDENTIALITY

All discussions during therapy sessions are confidential. Both verbal information and written records concerning a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make responsible attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.
Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

____________________________________ ____________
Signature (Parent/Guardian if under 18) Date

INFORMED CONSENT FORM

Client Name: ____________________ Date of Birth: ___________

I, ______________________________ hereby voluntarily consent to receive consultative, diagnostic, and therapeutic services and/or procedures from Synchrony Behavioral Health Services LLC as listed below:

Psychaitric evaluation

Family therapy

Individual Therapy

Medication Management

I understand the benefits of each service as well as the alternative to recommended treatment. Unless specifically stated otherwise, this consent form expires upon completion of services from Synchrony Behavioral Health Services LLC. I further understand that I am free to withdraw this consent for services at any time without prejudice to receiving alternative services from Synchrony Behavioral Health Services LLC. I may also be discharged from Synchrony Behavioral Health Services LLC if there is non-compliance with the agreed upon services.

______________________________ ___________

Client/Parent/Guardian Signature Date

CLIENT ACKNOWLEDGEMENT OF INFORMATION

My signature below is acknowledgement that the following information was reviewed and explained to me during the intake process:

- Privacy (HIPPA) Laws
- Client Rights as Participants
- Grievance Procedure
- Confidentiality of Records and Releases of Information
- Description of Services offered

As a client or designee of the client, my signature below indicates that I understand the information above. I agree to adhere to the policy, protocol and/or procedure to each of the items listed as they relate to me at any given time as a participant in Synchrony Behavioral Health Services LLC programs.

________________________________ ____________

Client/Parent/Guardian Signature Date

CANCELLATION POLICY

When an appointment is scheduled, that time is specially reserved for you. If the appointment is missed or cancelled without enough notice, we at Synchrony Behavioral Health Services LLC is unable to make use of that time. Therefore, appointments must be cancelled 24 hours in advance. If a client fails to provide 24 hours' notice, it is considered a "no show."

A $35 fee will be charged for missed appointments or no-show cancellations with less than 24 hours' notice unless due to illness or an emergency. A bill will be mailed directly to all clients who fail to show up or cancel their appointment.

Thank you for your consideration regarding this important matter.

____________________________________ _________________

Client Signature (Parent/Guardian if under 18) Date

CONSUMER RIGHTS

1. Be treated, always, with consideration and respect for your dignity, autonomy, and privacy.
2. Be informed of your rights.
3. Access mental health services and support
4. Be free from discrimination based on race, color, religion, national origin, language, culture, sex, age, marital status, personal appearance, sexual orientation, familial status, family responsibilities, matriculation, political affiliation, disability, source of income, or place of residence.
5. Be free from physical, emotional, sexual, or financial abuse, neglect, harassment, coercion, and exploitation when seeking or receiving mental health services and support.
6. Safe, sanitary, and humane treatment conditions.
7. Receive individualized and mental health services and mental health support in the least restrictive, most integrated setting appropriate for your needs.
8. Meaningful participation in the development of your individual recovery plan or individual plan of care, as well as the opportunity to participate in planning for your transition from one provider to another.
9. Be informed about your condition and legal status, and of proposed or current services, the risks and benefits of treatments, therapies, and other available alternatives. Unless otherwise provided by law, no services or support will be provided to you without your informed consent or the consent from legal guardians for minors.
10. Make healthcare decisions including the right to execute advance directives about medical treatment decisions and the right to execute a declaration of advance instructions about your mental health treatment preferences.
11. Be free from the administration of medication for the purpose of mental health treatment without your informed consent (or the legal guardian's consent for minors) unless otherwise provided by law.
12. Have your mental health information record and all information about you kept confidential unless otherwise provided by law.
13. Have access to your records in accordance with the Mental Health Information Act.
14. Participate in periodic evaluation of mental health services and mental health support, including an evaluation of our providers.
15. File a grievance if you feel that any of your rights have been limited or violated, or you are dissatisfied with the mental health services or mental health support being provided.
16. Request and receive an itemized copy of our bill for mental health services and mental health support.

Patient Name &
Signature____

Acknowledgement of receipt.: A copy of this document has been provided to the consumer and/or parent/guardian.

LABORATORY TESTS

I, ______________________________ understand that Synchrony Behavioral Health Services LLC Healthcare may recommend blood and/or urine, testing within their scope of practice. I agree with the use of such tests and always can discuss their applicability and limitations with my provider, prior to sample collection. I agree to pay the laboratory any fees due for sample collection and processing.

_________________________________ ___________

Client Signature (Parent/Guardian if under 18) Date

TELEHEALTH CONSENT

There may be times you will be scheduled for a telehealth visit.

I, ________________________________ consent to voluntarily engaging.
in a telemedicine consultation with Synchrony Behavioral Health Services LLC, when applicable. A HIPPA-compliant link will be sent prior to each scheduled telehealth appointment. I understand that the video conferencing technology will not be the same as a direct patient/health care provider visit. Telehealth consultation has potential benefits, including easier access to care, decreasing costs, and allowing visits to be performed from the comfort of my home. It also has potential risks including interruptions, unauthorized access, and technical difficulties.

I understand that my health care provider, or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

If there is another individual present during the telehealth consultation, I will be informed of their presence and I will also disclose if there is another individual with myself. It is agreed that these individuals will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:

1. Omit specific details of my medical history/physical examination that are personally sensitive to me.
2. Ask nonmedical personnel to leave the telemedicine space.
3. Terminate the consultation at any time.

I understand that telemedicine has limitations regarding physical examination. I understand that the physical exam portion of the care provided through the practice will be limited to inspection via video conferencing and some parts of the exam such as physical tests, examination of certain body parts, and vital signs may be conducted by individuals at my location at the direction of the consulting health care provider or not done at all.

Telemedicine services offered through Synchrony Behavioral Health Services LLC is not an Emergency Service. **In the event of an emergency or urgent medical issue, I will use a phone to call 911, go to the emergency department, or go to an urgent care.**

To maintain my privacy, I will not share telemedicine login information or video conferencing links with anyone unauthorized to attend the appointment.

____ ______________

Client Signature (Parent/Guardian if under 18) Date

TELEPHONE CONSULTATION CONSENT

I, ____understand that Synchrony Behavioral Health Services LLC, on rare occasions, allow telephone consultations - verbal conversation only / no video. I understand that these consultations have considerable limitations, including but not limited to no physical exam or visual assessment. I understand that my provider, during the telephone consultation, may determine that adequate care and treatment will not be possible with the limited assessment via telephone consultation. I agree to follow through with them on any required in-person office visits or video telehealth visits. I consent to receive instructions via phone/telemedicine platform and take full responsibility to follow through with specific instructions as required for my treatment. I have had the opportunity to discuss the limitations with my provider.

____________________________________ ____________

Client Signature (Parent/Guardian if under 18) Date

FINANCIAL POLICIES: FEES AND PAYMENTS

PHONE CALLS: Phone calls requiring 20 minutes or more of the provider's time will be charged as a minimum visit ($30/20 minutes).

PAST DUE ACCOUNTS: If your account becomes past due, we will take the necessary steps to collect this debt. At the time of your initial office visit, a copy of your credit card will be taken. If your account becomes past due over 60 days, that credit card will be charged. If the credit card declines or there are any other problems, your account will be referred to our collection agency. You will be charged for this service in addition to your current account balance. If payment is not received, your credit report will be blemished. If we have to refer the collection of the balance to a lawyer, you agree to pay all the lawyer's fees which we incur, plus all court costs.

COPIES: The cost for copies of lab work, chart notes, imaging, and invoices will be 50 cents per page, EXCEPT if requested at the time of the visit. Lab work, chart notes, and invoices pertinent to the visit will be provided free of charge on the day of the visit. Most documents will also be available for you on the patient portal.

SPECIAL LETTERS, FORMS, and DOCUMENTS: Completing special insurance forms, workplace documentation, writing letters of medical necessity, etc. require significant provider time and will be charged an administrative fee of $50 per document/letter. Fees must be paid in advance. Some documentation may require extensive time / complexity and may justify a higher fee. If so, this fee will be disclosed to you prior to preparing the documents.

Synchrony Behavioral Health Services LLC does NOT file for insurance reimbursement. All services are paid for by the patient at the time of service. You may pay cash, credit card, HSA card, or Flexible Spending Card. We will provide you with a superbill with all the necessary codes, so that you may file for reimbursement with your insurance company.

Insured clients: Copays are due at the time of service. Any fees not covered by the insurance company is the responsibility of the client.

Private Pay Clients: I clearly understand and agree that all services rendered to me will be charged to me, and that I am responsible for the full payment. I understand that even if I suspend or terminate treatment, any fees for professional services rendered to me or to my dependents up to the point of termination will be immediately due and payable.

I acknowledge that I am responsible for any outstanding fees for services provided to me by Synchrony Behavioral Health Services LLC.

You are required to pay all costs incurred during each visit in-full on the same day. These may include visit fees & additional services. We do not offer payment plans or issue outstanding balances.

REFUNDS: I UNDERSTAND THAT Synchrony Behavioral Health Services LLC WILL ISSUE NO REFUNDS, REGARDLESS OF MY RESULTS OR SATISFACTION WITH MY PERSONALIZED ACTION PLAN.

____ ______________

Client Signature (Parent/Guardian if under 18) Date

PRIVACY POLICY / HIPPA COMPLIANCE

OUR LEGAL RESPONSIBILITIES

We are required by law to give you this notice. It provides you with how we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We have the right to change these policies at any time. If we change our privacy policies, we will notify you of these changes immediately. This current policy is in effect unless stated otherwise. If the policy is changed, it will apply to all your current and past health information.

You may request a copy of our notice any time. Synchrony Behavioral Health Services LLC info@synchronybhs.com to request a copy of this privacy policy.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

The following examples describe ways that we may use your protected health information for your treatment, payments, healthcare operations etc., but please be advised that not every use or disclosure in a particular category will be listed.

- **Treatment:** We may use and disclose your protected health information to provide you with treatment. This includes disclosing your protected health information to other medical providers, trainees, therapists, medical staff, and office staff that are involved in your health care.
  For example, your medical provider might need to consult with another provider to coordinate your care. Also, the office staff may need to use and disclose your protected health information to other individuals outside our office, such as the pharmacy, when a prescription is called in.
- **Payment:** Your protected health information may also be used to facilitate payment or reimbursement to you from an insurance company or another third party. This may include providing an insurance company with your protected health information for pre-authorization for the medication we prescribed.
- **Health Care Operations:** We may use or disclose your protected health information to operate this medical practice. These activities include training students, reviewing cases with employees, utilizing your information to improve the quality of care, and contacting you by telephone, email, or text to remind you of your appointments.
  If we have to share your protected health information to third party "business associates" such as a billing service, if so, we will have a written contract that contains terms that will protect the privacy of your protected health information.
  We will not use or disclose your protected health information for any purpose other than those identified in this policy without your specific, written Authorization. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You can revoke this authorization at any time, but it will not affect the protected health information that was shared while the authorization was in effect.
- **Appointment reminders:** We may contact you as a reminder that you have an appointment for your initial visit, follow-up visit, or lab work via text, phone or email.

- **Others Involved in Your Health Care:** We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. For example, we may assume that if your spouse or friend is present during your evaluation, that we can disclose protected professional information to this person. 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 if there is an urgent or emergent need.
- **Research:** We will not use or disclose your health information for research purposes unless you give us authorization to do so.
- **Public Health Risks:** We may disclose your protected health information, if necessary, in order to prevent or control disease, report adverse events from medications or products, prevent injury, disability or death. This information may be disclosed to healthcare systems, government agencies, or public health authorities. We may have to disclose your protected health information to the Food and Drug Administration to report adverse events, defects, problems, enable recalls etc. if required by FDA regulation.
- **Health Oversight Activities:** We may disclose protected health information to health oversight agencies for audits, investigations, inspections, or licensing purposes. These disclosures might be necessary for state and federal agencies to monitor healthcare systems and compliance with civil law.
- **Required by Law:** We will disclose protected health information about you when required to do so by federal, state and/or local law.
- **Lawsuits:** We may disclose your protected health information in response to a court action, administrative action, or a subpoena.
- **Law Enforcement:** We may release protected health information to a law enforcement official in response to a court order, subpoena, warrant, subject to all applicable legal requirements.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- **Access to medical records:** You have the right to access and receive copies of your protected health information that we use to make decisions about your care. You must submit a written request to obtain your protected health information to the individual listed at the end of this privacy policy. We reserve the right to charge you a fee for the time it takes to obtain and copy the protected health information and provide it to you.
- **Amendment:** If you believe the protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information. You will need to submit a written request as to why you feel the health information should be amended. We may deny your request to amend it if you did not send a written request or give a reason why it should be amended. If we deny your request, we will provide you with a written explanation. We may deny your request if we believe the protected health information is accurate and complete.
- **Accounting of Disclosures:** You have the right to receive a list of instances in which we disclosed your personal health information unless the disclosure was used for treatment, payment, healthcare operations, was pursuant to a valid authorization and as otherwise provided in applicable federal and state laws and regulations. You must submit a written request to obtain this “accounting of disclosures” from the individual listed at the bottom of this policy. After your request has been approved, we will provide you with the dates of the disclosure, the name of the individual or entity we disclosed the information to, a description of the information that was disclosed, the reason why it was

disclosed, and any additional pertinent information. This information may not be longer than three years prior to the date the accounting is requested. We reserve the right to charge a reasonable fee for this process.

- **Restriction Requests:** You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. We shall accommodate your request except where the disclosure is required by law. We require this be a written request submitted to the individual at the end of this policy.
- **Confidential Communication:** You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. We must accommodate your request if it is reasonable and allows us to continue to collect payments and bill you.
- **Paper copy of this notice:** You may request a hard copy of this practice policy if you reviewed and signed it via electronic means. To obtain this copy, contact the individual at the end of this privacy policy.
- **Complaints:** If you believe your privacy rights have been violated, you may file a complaint with our office. You can also file a complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Name of Contact Person:
Doris Ogunmakinwa PMHNP-BC
Synchrony Behavioral Health Services LLC
info@synchronybhs.com

____________________________________ ____________

Client Signature (Parent/Guardian if under 18) Date