EMPOWERING MINDS
BODY AND WELLNESS CENTER

Giving you the Pe ace of Mind You Deserve

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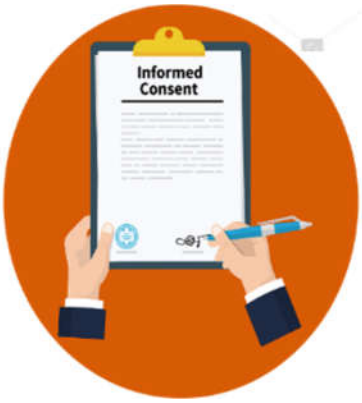
Traci@empoweringmindswellness.com

Consent Forms

Please read and review all the forms below carefully. If you have any questions, please contact us at any of the above methods.



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Notice of Privacy Practices

As required by the privacy regulations Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed.

At Empowering Minds Body and Wellness CTR. we are dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting business with us, we will create records regarding you and the treatment or services we provide to you.

We are required by law to maintain the confidentiality of your PHI, also to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at this time.

I understand that, under the (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that his information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the necessary healthcare providers who may be involved in that treatment directly or indirectly. As well as to obtain past medical history and prescription history when necessary.

2. Obtain payment for third-party payers such as Insurances etc.

3. Conduct normal healthcare operations such as quality mental and medical assessments and evaluations.

4. Our practice may use and disclose your PHI to contact you and remind you of an appointment via email, text and or call.

5. Disclosures required by law: Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

6. Notifying appropriate government agency and authority regarding the potential abuse or neglect of a patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.

7. Serious threats to your health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. Optional Release of information to family/friends: Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you.

Your Rights to you PHI:

You have the following rights regarding the PHI that we maintain about you:

1.Confidential communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or a specific method. In order to request a type of confidential communication, you must make a written request including your name, date of birth, address, telephone number and the specific requested method of contact. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2.***Requesting restrictions***: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or only certain individuals involved in your care or the payment for your care, such as family members and friends. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing including your name, D.O.B, address and telephone number.
Your request must be describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,

- To whom you want the limits to apply and Reason for your request

I understand that I may request in writing that I restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat me(patient).

3.Inspection and copies: You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including your medical records and billing records, but not including psychotherapy notes. You must submit your request in writing including your name, D.O.B, address and telephone number in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.

4.Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted with your name, D.O.B, address and telephone number, you must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5.Accounting of disclosures: All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. Please contact us for further details.

6. Right to a paper or Electronic copy of this notice: You are entitled to receive a paper or electronic copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time or download a copy from our website at empoweringmindswellness.com

7. Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health

and Human Services. To file a complaint with our practice. All complaints must be submitted in writing. For further instruction, please contact us. You will not be penalized for filing a complaint.

8.***Right to provide an authorization for other uses and disclosures:*** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. By Signing this agreement, you agree to the terms above.

Effective 01/01/2025

This Notice of Privacy Practice applies to Empowering Minds Body & Wellness CTR, By signing below you authorize the terms of Use/Disclosure of Protected Health Information.

Please Sign, print and date below:

Patient's Name: _____

D.O.B: _____ Tel: _____

Signature: _____ Date: _____

Signing on behalf of a minor please print your full name, address and contact number below.

Name: _____

Address: _____

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CONSENT FOR TREATMENT

Welcome to Empowering Minds Body and Wellness CTR. This document contains important information about our professional business policies, as well as the terms and condition for the treatment, payment, and health care services offered by our clinic. You have the right to revoke this agreement in writing at any time.

If I do not sign this consent, or later revoke it, Empowering Minds Body and Wellness CTR may decline to provide further treatment to you.
Please bring up any questions you have at your first appointment.

PLEASE PRINT YOUR NAME, D.O.B, ADDRESS, TELEPHONE NUMBER & DATE BELOW.

Patient's Name: D.O.B:
Tel: Date:
Address:

I give my consent for Empowering Minds Body and Wellness CTR to provide mental health or medical evaluation and/or treatment and Services. By participate in a medical or mental health evaluation and/or treatment and services at Empowering Minds Body and Wellness CTR, which includes treatment by a psychiatric mental health nurse practitioner and Family Nurse Practitioner.

All treatment or services and diagnostic studies as, in the judgement of the mental health and medical staff, may reasonably be necessary to preserve and protect the health and wellbeing of the Patient as well as to provide the best possible care.

I understand that there is no guarantee regarding the results of treatment. I understand that there are inherent risks in pharmacologic treatment and that there may be adverse side effects and results that are not anticipated. I also understand that the provider will go over any adverse side effects with me and will inform me of them and I understand that any side effects are also available from the pharmacy when I pick up the medication for my review and also should be read by the patient/guardian for a more in depth overview of the medication. I authorize the treatment with knowledge of possible risks and understand that I will be informed of possible adverse effects when applicable. I understand that communications between my provider and any other licensed professional and a patient are confidential. Confidentiality prohibits the disclosure of information related to the medical staff and patient relationship without consent from the patient or the patient's parent/legal guardian in a case of a minor.

I have completed the Empowering Minds Body and Wellness CTR, Notice of Privacy Practices for Authorization of the Use/Disclosure of my Protected Health Information, and have received and reviewed the Empowering Minds Body and Wellness CTR Authorization and Consent to Participate in In-Person and Tele-Health Consultation form. I understand I can withdraw this consent for mental health/medical treatment and or services at any time by providing written notice to Empowering Minds Body and Wellness CTR.

Instructions for signing the form: ***If you are a Parent or Legal Guardian signing this form on behalf of minor, please provide us with your name and relationship to the patient as well as your address and contact information.***

If you are the Patient signing this form only print your name, date and your signature all other information is not applicable to you.

Patient's Name:

Signature: Date:

Signing on behalf of a minor please fill out below.

Name of Signer:

Relationship to Patient:

Address:

Tel:

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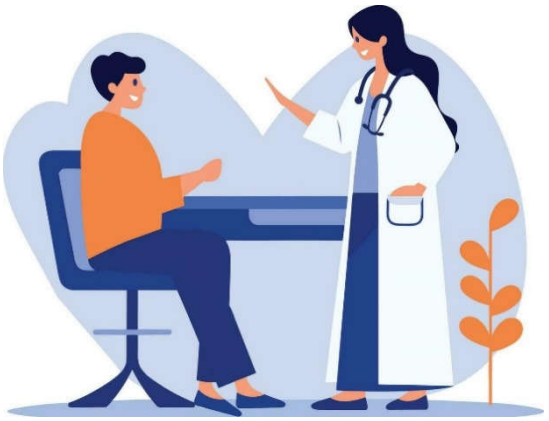
AUTHORIZATION AND CONSENT TO PARTICIPATE IN IN-PERSON AND TELE-HEALTH CONSULTATION



The purpose of this form is to obtain your consent to participate in in-person and a tele-health consultation with **Empowering Minds Body and Wellness CTR**

The purpose of Tele-health is to enable patients to have access the necessary care they need in an environment that is comfortable and safe for them.

Office Hours: Are listed on the website at empoweringmindswellness.com and are by appointment only. We may close the office for holidays or vacations, and this will be stated on the telephone voicemail greeting.

1. I understand that the same standard of care applies to a tele-health visit as applies to an in-person visit.

2. I understand that I will not be physically in the same room as my health care provider for tele-health care. I will be notified of and my consent obtained for anyone other than my healthcare provider presents in the room.

3. I understand that there are potential risks to using technology, included service interruptions, interceptions, and technical difficulties. - If it is determined that the

videoconferencing equipment and/or connection is not adequate, I understand that my healthcare provider or I may discontinue the tele-health visit and make other arrangements to continue the visit.

4. I understand that I have the right to refuse to participate or decide to stop participating in a tele-health visit and or In-person visit, and that my refusal will be documented in my medial record. I also understand that my refusal will not affect my right to future care or treatment.

5. I understand that the laws that protect privacy and the confidentiality of health care information apply to tele-health services and In-person visits.

6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes and my insurance carrier will have access to my medical records for quality review/audit.

7. I understand that I will be responsible for any out-of-pocket costs such as copayments or co-insurances that apply to my telehealth visit or in office visit.

8. I understand that health plan payment policies for telehealth visits may be different from policies for in-person visits.

9. If there is a change in your insurance coverage, your address, or other important demographic information between appointments, please let us know when you check in, It is your responsibility to ensure your personal data is up to date.

10. **THREE (3) NO SHOWS** in a row will result in termination of services

Please sign below to agree to the said terms above. By signing this form, you attest that you fully understand the terms of this agreement. If you have any questions, please contact us and we will answer all questions to the best of our abilities.

Patient's Name:

Signature: Date:

Signing on behalf of a minor please print your full name below.

Name:

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Medication Management and Refill Policy

Empowering Minds Body and Wellness CTR participates with electronic prescribing directly to your mail order and local pharmacies. Our goal is to assist our patients with prescription requests in an efficient and timely manner.

Please note: Medication shortages are a very common occurrence. If your medication is out of stock at your preferred pharmacy, it is your responsibility to find a pharmacy that has it in stock.

Due to the volume of prescription requests, we have created the following guidelines to help meet these goals.

1. Prescription refills require close monitoring by your provider to ensure its safety and effectiveness. Your provider will prescribe the appropriate number of prescription refills to last until your next scheduled appointment. Generally, when you are down to zero refills, it is time to schedule a follow-up appointment.

2. Patients requesting new prescriptions must be seen for an appointment. They are not prescribed over the phone because it generally requires an office visit or a tele-health video conferencing session.

3. It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no-shows or cancellations will result in a denial of refills.

4. If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please contact us immediately.

5. It is the patient's responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to 2-5 business days.

6. Medication refills will only be addressed during regular office hours. Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled after hours, when the clinic is closed for vacation or on Holidays.

7. Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

8. Some medications require prior authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

Please sign below to agree to the said terms above. By signing this form, you attest that you fully understand the terms of this agreement. If you have any questions, please contact us and we will answer all questions to the best of our abilities.

Patient's Name: _____

Signature: _____ Date: _____

Signing on behalf of a minor please print your full name below.

Name: _____

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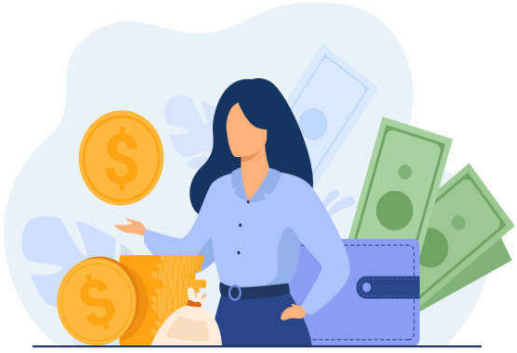

Agreement for Self-Payment of Services

Empowering Minds Body and Wellness CTR only accepts the insurances Optum, Cigna, Quest, Aetna, Carelon and are working to be credentialed with more insurances. For a complete list of the insurances we accept visit our website empoweringmindswellness.com. We are currently not credentialed to accept any other health insurances whatsoever, If you do not have one of the accepted insurances listed on the website then your services are to be **100% self-paid by the patient.** I understand. By signing this form, I acknowledge that one or more of the following statements apply to me below. Statements followed:

1) You do not have any health insurance through a, PPO, HMO, Medicaid or Medicare or any other insurance plan.
2.) You have health insurance, but you do not want to use any insurance benefit for these services.
3.)You acknowledge that we do not accept your health insurance.

Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits, and how they will apply to your benefit payments, and we take no responsibility to understand or be bound by the terms and conditions of such insurance.

By signing this form, you have selected services for purchase on a self-pay basis. In other words, you have directed us to treat your purchase of these services as if you are an uninsured patient and you agree to be **100% responsible for full payment** of the listed price of the services.
Forms: I understand that there are fees associated with completing medical forms.Simple forms fee is $25-$50.00 USD, i.e school forms 1 page letters, Complex forms fee is $50- $75 per form i.e FMLA & disability forms depending on the complexity of form and number of pages. I understand that the fee must be paid in full before the form will be filled out and it may take 2-7 days to be completed.

There is no guarantee your insurance company will make any payment on the cost of the services you have purchased. Your licensed provider will provide you with the charges, in advance, for the services you have requested. I also understand that if I do not cancel my appt. within 24 hrs of my scheduled appt. a $75.00 USD fee will be charged to my account and if I NO SHOW a $100.00 USD fee will be charged to my account and I can't be seen by the provider until all fees are paid. **By sigining this form, you agree to pay these charges in full as a self-paid patient, electing not to use an insurance policy benefit. You have been given a choice of different services, along with their costs. You have selected the services and are willing to accept full financial responsibility for payment.**

Patient's Name:

Signature: Date:

Signing on behalf of a minor please print your full name below.

Name: