New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC
125 Broad Street, One Broad Street Plaza, Glens Falls, NY 12801
phone: 518.744.7302 fax: 518.909.6423 www.newhopepsychnpservices.com

Basic Demographics

Patient Information:

First Name: Middle Name: Last Name:
Sex: Date of Birth:
Social Security #: E-mail:
Home Phone #: Cell Phone #: Preferred Phone:
Marital Status:
Mailing Address:
Residential Address:
City: State: Zip Code:

Primary Insurance:
Subscriber Name:
Payer Name:
Policy Start Date: Policy End Date:
Policy #: Group #:

Secondary Insurance:
Subscriber Name:
Payer Name:
Policy Start Date: Policy End Date:
Policy #: Group #:

Emergency Contacts: (Please note that we require two emergency contacts for each patient.)
Emergency contact name:
Emergency contact's relation to patient:
Emergency contact's phone number:

Emergency contact name:
Emergency contact's relation to patient:
Emergency contact's phone number:

Preferred Pharmacy:
Address:
Phone Number:

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Permission to Bill Insurance, Receive Insurance Payment, and Collection Policy

Signature of guarantor, insured party, or authorized person's signature certifies that:

I authorize payment of the medical benefits to New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC, and understand that I am responsible for all balances not covered by my insurance company, such as co-payments, co-insurance, deductibles, and non-coverage of benefits. I understand that my co-payment is due at the time of service, and if this account becomes delinquent, it may be turned over to a collection agency, and the fact that I received treatment in this office will become public record. I understand that there is a $50.00 no-show charge if I do not cancel appointments 24 hours in advance. If I do not pay my co-pay at the time of my service date, a $10.00 late fee will be charged. On any balance 6 months overdue, 18% APR and a $50.00 collection fee will be added.

Patient/Guardian Signature:_____ Date:_____

Print Name:

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Informed Consent for Medication Management-Psychotherapy

This form documents that I give my consent to my provider at New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC (the "psychiatric nurse practitioner") to provide medication management and psychotherapeutic treatment to me (or my child). If my child is being treated, I understand that sometimes it is necessary to conduct family therapy as part of the treatment for the child.

While I expect benefits from this treatment, I fully understand that no particular outcome can be guaranteed. I understand that I am free to discontinue treatment at any time, but that it would be best to discuss with the psychiatric nurse practitioner any plans to end therapy before doing so.

I have fully discussed with the psychiatric nurse practitioner what is involved in medication management, and I understand and agree to the policies about scheduling, fees, and missed appointments.

- I understand that I am fully financially responsible for treatment, which, if I have health insurance, includes any portion of the psychiatric nurse practitioner's fee that are not reimbursed by our insurance.
- I understand that the frequency of our sessions will be ***1-4x PER MONTH***, and that I am fully responsible for payment of all deductibles and co-payments.
- I understand that payment will be due at the time services are rendered.
- I understand that I will be charged $50.00 for any canceled sessions if I do not give the psychiatric nurse practitioner at least ***24 BUSINESS HOURS*** notice. For example, if I call at 2pm on Sunday to cancel a Monday appointment, I will be billed $50.00. (Insurers don't pay for canceled sessions.)
- I understand that there will be a $10.00 charge if I do not pay my co-pay at the time services are rendered.
- I understand that if my bill is not paid in full within 6 months of the unpaid date of service, in addition to an 18% APR, a $50.00 collection fee will be added.

Our discussion about therapy has included the psychiatric nurse practitioner's evaluation and diagnostic formulation of my problems, method of treatment, goals, and length of treatment, and information about record-keeping. I have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. I understand that therapy can sometimes cause upsetting feelings to emerge, that I may feel worse temporarily before feeling better, and that I may experience distress caused by changes I may decide to make in my life as a result of therapy.

I understand that during supervision the patient's name, diagnosis, and treatment plan are shared with the supervisors. I also understand that during the course of treatment, pertinent information is shared with the supervisors. As always, all providers abide by privacy policies and HIPAA.

I understand that in order to work with New Hope's psychiatric nurse practitioners, I must provide at least two emergency contacts prior to the first appointment.

I understand that the psychiatric nurse practitioner cannot provide emergency service. If an emergency arises, I will call the phone numbers as follows: Drs. Scarano and Osika, 518-744-7978 and 518-791-5904. In any case, I understand that in any emergency I may call 911 or go to the nearest hospital emergency room. I understand that Glens Falls Hospital has an Emergency Mental Health Staff, and they can be reached at 518-761-5325.

I have received a HIPAA Notice of Privacy Practices from the psychiatric nurse practitioner. I understand that information about medication management is almost always kept confidential by the psychiatric nurse practitioner and not revealed to others unless I give my consent. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Details about certain of those exceptions follow:

1. The psychiatric nurse practitioner is required by law to report suspected child abuse or neglect to the authorities.

2. If I tell the psychiatric nurse practitioner that I intend to harm another person, the psychiatric nurse practitioner must try to protect that person, including by telling the police or the person or other health care providers. Similarly, if I threaten to harm myself, or my life or health is in any immediate danger, the psychiatric nurse practitioner will try to protect me, including by telling others, such as my relatives, or the police, or other health care providers, who can assist in protecting or assisting me.

3. As per Section 9.46 of the Mental Health Hygiene Law, the psychiatric nurse practitioner is mandated to report (at https://nvsafe.omh.nv.gov) patients who are at imminent risk of harming themselves or others. Such a report could have direct implications as to whether or not I could possess a firearm.

4. If I am involved in certain court proceedings, the psychiatric nurse practitioner may be required by law to reveal information about my treatment. These situations include child custody disputes, cases where a therapy patient's psychological condition is an issue, lawsuits or formal complaints against the psychiatric nurse practitioner, civil commitment hearings, and court-related treatment.

5. If my health insurance or managed care plan will be reimbursing me, or paying the psychiatric nurse practitioner directly, they will require that I waive confidentiality, and that the psychiatric nurse practitioner give them information about my treatment.

6. The psychiatric nurse practitioner may consult with other psychiatric nurse practitioners about my treatment, but in doing so will not reveal my name, or other information that might identify me. Further, when the psychiatric nurse practitioner is away or unavailable, another psychiatric nurse practitioner might answer calls and so will need to have some information about my treatment.

7. If my account with the psychiatric nurse practitioner becomes overdue, and I do not pay the amount due or work out a payment plan, the psychiatric nurse practitioner will reveal a limited amount of information about my treatment in taking legal measures to be paid. This information will include my name, social security number, address, dates and type of treatment, and the amount due.

In all of the situations described above, I understand that the psychiatric nurse practitioner will try to discuss the situation with me, or notify me, before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

If your child is the patient, I attest to the following (disregard if you are the adult patient):

1. I understand that, except in exceptional circumstances, the psychiatric nurse practitioner cannot keep secrets from other family members who are involved in the therapy, because this might harm the person who does not know.

2. We agree that each of us has, and shall continue to have, the right to information about our individual, family, and/or conjoint treatment sessions, and to the treatment records of the psychiatric nurse practitioner regarding our individual, family, and/or conjoint treatment sessions. We each agree that the psychiatric nurse practitioner may release such information or records to either or all of us without any additional authorization(s) from the other(s). We understand that each of us will not, however, have any right of access to information or records regarding individual treatment sessions of other family members.

3. We agree that if marriage or parenting problems lead to legal disputes over child custody or visitation, neither of us will ask, nor require, that the psychiatric nurse practitioner testify regarding custody or visitation, because to do so would hurt the child's treatment. The psychiatric nurse practitioner's role is therapeutic, and not evaluative. We understand that a third-party forensic professional best answers these legal disputes.

4. If a custody or visitation proceeding does occur, we agree that the psychiatric nurse practitioner's role will be limited to providing information to a mental health professional appointed to perform a forensic evaluation, the attorneys, law guardian, and/or the judge involved in the legal proceeding. The psychiatric nurse practitioner will provide these either as required by law, or upon our authorization. Because of these limitations, the psychiatric nurse practitioner also will not be able to give any opinion regarding custody, visitation, or any other legal issue.

5. We understand that we have rights to information about what takes place in the child's treatment, to information about the child's progress, to information about any dangers the child might present to self or others, and, upon request, to obtain copies of the child's treatment record (with certain qualifications and exceptions). We understand that it is sometimes best not to ask for specific information about what was said in sessions, because this might break the trust between the child and the psychiatric nurse practitioner, especially for children over the age of 12.

6. The psychiatric nurse practitioner has explained to us that children with two parents have the best chance to benefit from treatment if both parents are involved, and cooperate with each other and the psychiatric nurse practitioner. It is best if both the child's parents consent to treatment.

7. Each of us agrees that he or she will not end the child's treatment without the agreement of the other parent, and that if we disagree about the child's continuing, we will try to come to an agreement, by counseling if necessary, before ending the child's treatment.

8. We each agree to cooperate with the treatment plan of the psychiatric nurse practitioner for the child, and understand that without mutual cooperation the psychiatric nurse practitioner may not be able to act in the child's best interests, and may have to end treatment.

9. We agree that each of us has, and shall continue to have, the right to information about the child's treatment, and to the treatment records of the psychiatric nurse practitioner regarding the child, and agree that the psychiatric nurse practitioner may release information or records to either of us without any additional authorization of the other(s).

If we and/or the child are participating in a managed care plan, we have discussed with the psychiatric nurse practitioner our financial responsibility for any co-payments, and the plan's limits on the number of therapy sessions. If we and/or the child are not participating in a managed care program, we understand that we are fully financially responsible for treatment, including any portion of the fees not reimbursed by health insurance. The psychiatric nurse practitioner has also discussed options for continuation of treatment when managed care or health insurance benefits end.

I have the right to be notified of a data breach. I have the right to ask for an electronic copy of my medical record. I have the right to opt out of fundraising communications from us. Uses and disclosures of your medical information cannot be sold or used for marketing purposes without your authorization. All patients who pay in full out of pocket for services (i.e., do not bill their insurance) can instruct us to not share information about your treatment with your health plan. If I am participating in a managed care plan, I have discussed with the psychiatric nurse practitioner my financial responsibility for any co-payments and the plan's limits, if any, on the number of therapy sessions. I have discussed with the psychiatric nurse practitioner my options for continuation of treatment when my managed care benefits end. If I am not participating in a managed care program, I understand that I am fully financially responsible for treatment.

I understand that under HIPAA, I have the right to request that communications with the psychiatric nurse practitioners' office be confidential, and by means of my selection. I understand that the psychiatric nurse practitioners' office will approve my request if it is reasonable and made in writing. Once agreed upon, the psychiatric nurse practitioners' office is obligated to honor it, except if an emergency arises. I allow the administrative and professional staff at New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC to contact me by telephone at my home and at my work, and in writing at my home, unless I instruct them otherwise. Phone messages will be left with minimal information: the provider's name and call back number. Any requests I have for alternative means of, or limits to my communication with, your staff (e.g., specific times of day to call) will be made in writing. I understand that I have a right to ask the psychiatric nurse practitioner about the psychiatric nurse practitioner's training and qualifications.

I understand that if I decline to grant consent to access my medical history information via HIXNY, this may adversely affect response to treatment.

I understand that I have a right to ask the psychiatric nurse practitioner about the psychiatric nurse practitioner's training and qualifications, and about where to file complaints about the psychiatric nurse practitioner's professional conduct. If I ever desire to file a complaint about the psychiatric nurse practitioner's professional conduct, I understand that I can call the NYS Department of Education at 518-474-3817. Complaints to the licensing board can also be made if you feel your provider or any staff member of New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC violates your patient rights, or discriminates against you based on gender, race, sexual orientation, national origin or color. If the licensing board finds that an employee of New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC has violated this non-discrimination policy, appropriate disciplinary action, ranging from counseling to termination, will be taken against the employee who violated the policy. (If you desire to file a complaint about a staff member, please either call Dr. Gina Scarano-Osika at 518-744-7978, or email her at dr.osika@ymail.com.)

Patients (or parents) may audio record sessions, but only with our express written permission. Any violation of this policy will result in our beginning a treatment termination process.

If you are in crisis after hours or on weekends, please text URGENT to both 518-744-7978 and 518-791-5904. Also, please call the Suicide Crisis Line at 988.

If you need a refill on your medication as prescribed by New Hope, please text 518-744-7978 and state your name, date of birth, the name of your prescriber, and the medications you need refilled. Please do this 72 hours in advance of your last dose.

At some point in your treatment at New Hope the psychiatric nurse practitioners may deem you to need psychotherapy. They have the right to mandate psychotherapy in order to continue to prescribe your medications.

By signing below, I indicate that I have read and understand this form, and that I give my consent to treatment.

Patient/Guardian Signature:_____ Date:_____

Print Name:

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Informed Consent for Psychiatric Medications

THIS FORM DOCUMENTS THAT YOU AND I HAVE DISCUSSED YOUR MEDICATION(S) TO YOUR SATISFACTION.

I have recommended the following medication(s). I have either told you about the medication(s), or given you written information, or both. You are entitled to know the following information before deciding whether to take the medication(s):

1. What your condition or diagnosis is.
2. What symptoms the medication(s) should reduce and how likely the medications are to work.
3. What your chances are of getting better without the medication(s).
4. What other reasonable treatments are available.
5. The name, dosage, frequency, route of administration and duration of prescribed medications.
6. Side effects of the medications known to commonly occur.
7. Any special instructions about taking the medications.

Medication **Daily Dose**

By signing this form, I indicate the medications have been explained to you to your satisfaction. Even after signing, I may still refuse any medication, ask questions about my medications, or withdraw my agreement completely, at any time. I will receive a copy of this consent form. I have had the opportunity to receive information about my medications from you, and I consent to this treatment. I also understand that the first appointment is an assessment intended to develop a care plan, and that medication may not necessarily be immediately prescribed. I understand that I may be refused treatment, and referred to a more appropriate level of care.

Please check one of the following:

- ❑ I have had the opportunity to receive information about my medications from you, and I consent to this treatment. I understand I can ask questions about my medicines at any time. (INFORMED CONSENT.)
- ❑ I have had the opportunity to discuss information about the medications with you, and **I refuse** to consent to the medications recommended. I understand that you will continue to offer me the chance to take medicine, and information about it, but that I may continue to refuse the medicine. (INFORMED REFUSAL.)
- ❑ The patient verbally consents to the recommended medications, but refuses to sign because:

_____

Patient/Guardian Signature:_____ Date:_____

Witness (if patient unable or unwilling to sign):_____ Date:_____

Donna Finn-Kuo
Donna Finn-Kuo, PMHNP-BC

Valerie Ramsey
Valerie Ramsey, MS, PMHNP-BC

Brandy Wadsworth
Brandy Wadsworth, MS, PMHNP-BC

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Consent for Telemedicine

I hereby consent to engaging in telemedicine with (psychiatric nurse practitioner) as part of my treatment. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, and treatment using interactive audio-video communications. I also understand that, with my signed consent, telemedicine may involve the electronic communication of my medical/mental healthcare information to other health care practitioners. The rights stated supplement those rights I have generally as a patient of the psychiatric nurse practitioner.

I understand that I have the following rights with respect to telemedicine: I have the right to withhold or withdraw consent to telemedicine treatment at any time. The laws that protect the confidentiality of my medical/healthcare information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are mandatory exceptions to confidentiality, including reporting child abuse and the imminent risk of danger to self or others. If I put my mental state at issue in certain legal proceedings, then the psychiatric nurse practitioner may be compelled to release otherwise confidential information about my evaluation and treatment.

I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychiatric nurse practitioner, that the transmission of my medical information could be disrupted or distorted by technical failures or unauthorized persons, and that the electronic communication of my medical information could be accessed by unauthorized persons. I understand that telemedicine-based services and care may not be as complete or effective as face-to-face services. I also understand that if my psychiatric nurse practitioner believes I would be better served by in-person medication management services, I will be referred to a psychiatric nurse practitioner who can provide such services in my area.

I understand that there are potential risks and benefits associated with any form of medication management, and that despite my efforts and the efforts of my psychiatric nurse practitioner, my condition may not improve, and in some cases may even get worse. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured. As with all medical records, I understand that I have a right to access my medical information and copies of medical records of telemedicine treatment in accordance with New York State law.

If I am temporarily to be outside of New York State at any time during my telemedicine treatment, then I also hereby represent that I am a permanent resident of New York State. I understand that the psychiatric nurse practitioner is licensed in New York State, and that I have recourse to the professional licensing board and courts of New York State should I have any grievance against the psychiatric nurse practitioner.

I have read and understand the information provided above. I have discussed it with the psychiatric nurse practitioner, and all of my questions have been answered to my satisfaction. My signature below indicates my informed consent to treatment.

Patient/Guardian Signature:_____ Date:_____

Print Name:

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Release of Information to Primary Care Physician and Osika & Scarano Psychological Services

(If you decline to authorize the release of your information at this time, please continue to the following page.)

1. I authorize my healthcare practitioner, at New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC and/or administrative and clinical staff to disclose my protected health information to my Primary Care Physician, and to the staff of Osika & Scarano Psychological Services.
2. I am hereby authorizing the disclosure of my Diagnostic Examination, Treatment Plan, lab tests and medications.
3. This protected health information is being used or disclosed for the following purposes: To collaborate regarding the treatment plan and diagnosis.
4. This authorization shall be in force and affect until one (1) year after the date below, at which time this authorization to disclose protected health information shall expire.
5. I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to my healthcare practitioner at: New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC. I understand that a revocation is not effective to the extent that my healthcare practitioner has relief on my authorization, or if my authorization was obtained as a condition of obtaining insurance coverage, and the insurer has a legal right to contest a claim.
6. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law.
7. My healthcare practitioner will not condition my treatment on whether I provide an authorization for disclosure, except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient/Guardian Signature:_____ Date:_____

Print Name:

Date of Birth:

(Provide a copy of this form to the patient.)

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Refusal to Release Information to Primary Care Physician (OPTIONAL)

ONLY SIGN THIS FORM IF YOU REFUSED TO SIGN THE PREVIOUS PAGE

According to HIPAA, you have the right to refuse to give consent for your psychiatric nurse practitioner at New Hope Psychology and Nurse Practitioner-Psychiatry PLLC to coordinate care with your Primary Care Physician (PCP). Your insurance company, however, requires documentation of this refusal, and an explanation of the reason.

Reasons why you feel that coordination of care with your PCP is not necessary may include:

1. I need to discuss very personal issues that I do not want shared with my PCP.
2. I may consider signing a release at a later date as I gain trust in my provider at New Hope.
3. I may consider signing a release at a later date as I discuss the things I do and don't want released to my PCP.
4. I just don't feel it is necessary at this time.
5. Other.

Patient/Guardian Signature:_____ Date:_____

Print Name:

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Release of Information / Authorization Form

(If you decline to authorize the release of your information at this time, please continue to the following page.)

1. I authorize my healthcare practitioner, at New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC, and/or administrative and clinical staff to exchange my protected health information, as specified below, with the persons and organizations indicated below:

2. I am hereby authorizing the disclosure of the following protected health information:
   Examinations, treatment plans, and progress notes.

3. This protected health information is being used or disclosed for the following purposes:
   To collaborate regarding diagnosis and treatment of the patient.

4. This authorization shall be in force and affect until one (1) year after the date below, at which time this authorization to disclose protected health information shall expire.

5. I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to my healthcare practitioner at: New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC, 125 Broad Street, One Broad Street Plaza, Glens Falls NY 12801. I understand that a revocation is not effective to the extent that my healthcare practitioner has relief on my authorization, or if my authorization was obtained as a condition of obtaining insurance coverage, and the insurer has a legal right to contest a claim.

6. I understand that information disclosed pursuant to this authorization may be disclosed by the parties indicated above, and may no longer be protected by HIPAA or any other federal or state law.

7. My healthcare practitioner will not condition my treatment on whether I provide an authorization for disclosure, except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient Name:

Patient/Guardian Signature:_____ Date:_____

Print Name:

Date of Birth:

(Provide a copy of this form to the patient.)

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Patient Request for Confidential and Electronic Communications

We at New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC., assume that we may contact you by telephone at your home and at your work, and in writing at your home, unless you instruct us otherwise.

Under HIPAA, you have the right to request that communications with you be confidential, and by means of your selection. We will approve your request if, in our opinion, it is reasonable. Once we agree to your request, we are obligated to honor it, except if an emergency arises.

If you have any restrictions on how you would like our staff to contact you, please submit them in writing to the office staff.

I agree that my PHI may be transmitted electronically (via email), which I understand is not HIPAA Compliant. Since transmitting ePHI is not standard procedure at New Hope, you need to authorize us to send and receive such information electronically. By signing below, you authorize us to send and receive your PHI electronically. I understand that although the electronic devices and e-mail at New Hope are password-protected, the privacy of my PHI may be breeched by forces beyond our control (e.g., hacking, stolen devices, et al.). I understand I should delete any correspondence with our office from my e-mail and phone as soon as possible, which is a standard and customary procedure by all staff at New Hope Psychology and Nurse Practitioner-Psychiatry Services, PLLC. Once signed, this waiver will be in effect until the office is notified in writing.

I also understand that if I, in any way, feel that my requests are violated or that my general rights to confidentiality are breeched, I can contact the owners of New Hope: Drs. Tom and Gina Osika at (518) 744-7978 or 791-5904.

Patient/Guardian Signature:_____ Date:_____

Print Name:

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Liability for Inaccurate Insurance Information

In order to minimize my out-of-pocket expenses, I understand that I am fully responsible for updating my insurance information on a yearly basis and when my insurance changes. Failure to give immediate notice of any change in insurance can result in large out-of-pocket expenses, which I will be fully liable to pay in full.

By signing below I am confirming that the name of my insurance and the ID number are correct. I am also confirming that I know what my co-pay is and whether or not I have a deductible. I also acknowledge that I am not aware that any mental health services, testing or sessions require a prior authorization.

By signing below, I am agreeing to pay in full any outstanding balance that results from incomplete or inaccurate information.

Patient/Guardian Signature:_____ Date:_____

Print Name:

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Professional Policies

Welcome to New Hope Psychology and Nurse Practitioner-Psychiatry Services! We are honored to be a part of your journey towards mental wellness!

Please take a moment to review some important information about our professional policies.

1. Please allow 2-3 business days for a reply to any messages.
2. Controlled substance refill requests should be made 3 business days in advance to avoid interruption of treatment.
3. Routine medication refill requests will not be addressed after hours or on the weekends.
4. Please note that failure to keep scheduled appointments may result in an inability to refill your medications.
5. If you require medical emergency services, please call 911, or proceed to the nearest hospital emergency room. If you have an urgent mental health-related problem after hours which cannot wait until the next business day, you may text "URGENT" to Dr. Gina Scarano-Osika at 518-744-7978, or to Dr. Tom Osika at 518-791-5904. You may also attempt to contact your therapist during their working hours.
6. We request that you follow the treatment plan which is developed collaboratively with you. This means taking all medications as directed, keeping appointments, obtaining bloodwork as directed, following through with referrals to therapists and other health care providers, substance abuse treatment, etc.
7. Agreement to consent to participate in New York State's Prescription Monitoring Program.
8. Agree to provide 2 emergency contacts.
9. Grounds for dismissal include abuse of medications, non-compliance with treatment plan, being disrespectful to provider or administrative staff, or missing 3 consecutive appointments without appropriate advance notice.
10. A higher level of care may be recommended if safety concerns are identified, treatment progress is limited or stalled, if there is evidence of a significant reduction in ability to function, an increase in symptoms, or co-occurring substance use/abuse disorders.

Thank you for entrusting us with your care. We will do our very best to serve you well!

By signing below, I indicate that I have read and understand this form.

Patient/Guardian Signature:_____ Date:_____

Print Name: