Chelmsford Behavioral Health, LLC
73 Princeton st., Suite 304, N. Chelmsford, MA 01863
Tel: 978-455-3141 Fax: 978-455-3069

Telehealth Consent Form

Telepsychiatry provides psychiatric services using interactive video conferencing tools, such as doxy.me, in which the psychiatrist and the patient are not at the same location. Telepsychiatry will allow the patient to receive medical care without the need to visit the office and travel long distance. Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in medical evaluation and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face to face visit may result in errors in medical judgment. Alternative to telepsychiatry include traditional face to face sessions.

Your Rights:

1) I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry;
2) I understand that the doxy.me is known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. You can review the security features of doxy at http://doxy.me

3) I have the right to withdraw my consent to the use of telepsychiatry during the course of my care at any time.

4) I understand that my counselor or prescriber has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time;

5) I understand that all rules and regulations which apply to the practice of medicine in the State of Massachusetts also apply to telepsychiatry.

Your Responsibilities:
1) I will not record any telepsychiatry sessions without the prior written consent of counselor or prescriber and I understand that counselor or prescriber will not record telepsychiatry sessions without my consent;
2) I will inform my counselor or prescriber if any other person can hear or see any part of our session before the session begins. Likewise, my counselor or prescriber will inform me if any other person can hear or see any part of the session before the session begins.

3) I understand that I MUST be a resident of Massachusetts to be eligible for telepsychiatry services from my counselor or prescriber.
4) I understand that my Initial Consultation will not be done by telepsychiatry except in special

circumstances under which I will be required to verify my identity to my counselor or prescriber's satisfaction before the evaluation.

Your signature below indicates that you have read and understand the information provided above regarding telepsychiatry, and that you authorize counselor or prescriber to use telepsychiatry in the course of diagnosis and treatment.

x_____ x_____

Patient or Parent/Legal Guardian Signature Date

x_____ x_____

Patient's name Relationship to patient

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Formerly Oasis Behavioral Health, LLC

March 11, 2025

Dear Client,
We are writing to inform you that all Telehealth visits must be video calls going forward. Please make sure that you are signed in early for your appointment. If something goes wrong or you can't get the video to start, you can call our office.

Chelmsford Behavioral Health platform uses secure and encrypted communication methods to protect the privacy of our patients. There are 2 options for your video Telehealth visit.

Our MYIO app or thru the web: https://valant.io/myio/OBHLLC

Our DOXY video call could be found on our web:
https://www.chelmsfordbehavioralhealth.com/appointments

Ensure that you are in a private area where you can speak openly
Please DO NOT conduct your visit while DRIVING, SHOPPING, or DISTRACTED BY OTHERS

Sincerely yours,
Chelmsford Behavioral Health, LLC

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PRACTICE POLICIES AND PROCEDURES
Consent for Treatment

I consent to evaluation and medically necessary treatment by my provider(s) at Chelmsford Behavioral Health. I understand this consent does not constitute a guarantee about the results of my treatment. I understand I can terminate this consent for treatment at any time. I also understand that my provider may terminate consent for treatment at any time and will
discuss the reasons with me if this should occur. Potential reasons include: misusing presc ribed medications, misusing provider services, frequent cancellations and/or no shows, failure to remit payment for services, etc.

Privacy Practices

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Agreement to Pay

I agree to pay my provider all charges for professional services. Payment is expected at the time of service, as balances are not allowed to accumulate. Any accumulated charges must be paid prior to any subsequent visit. Payments may be made via check, cash, or credit cards.

Fees for Services

I understand that my provider may or may not participate with my insurance company. This includes private insurance companies, Medicare, and Medicaid. The patient is responsible for payment in full at the time of service. The current fees for appointments range from $145 to $350 depending on the services provided and length of session.

Insurance Benefits

I understand that my provider may or may not participate (is Out-Of-Network) with my insurance company. However, many insurance companies allow for Out-Of-Network provisions. In these situations, the patient is able to submit a form to their insurance company after each office visit and may be partially reimbursed for their expenses. At the patient's request, the provider will issue the patient with the proper form to submit to their insurance company. It is the patient's responsibility to inquire about these services through their insurance company. If the insurance company requires any authorization from the provider, I understand I may be charged for this service.

Additional Charges for Services

I understand there are additional services that may require billing as well. These include but are not limited to:

- Legal depositions contact with attorneys

- Writing of reports for your insurance company or for your employer
- Obtaining Prior Authorizations for medications through your insurance company
- Returned phone calls longer than 10 minutes in duration
- Excessive phone calls
- Returned checks (fee of $50)
- Fees associated with collections

I fully understand that I will be personally responsible for these charges. The provider reserves the right to charge for these services on a prorated fee of $150 per hour or may require the patient to schedule an office appointment to address these services.

Initial Evaluation Appointment

I understand that the initial evaluation appointment with the provider is an evaluation only. At the end of the evaluation process, I may be provided with a working diagnosis and/or treatment recommendations which may include services that is unable to provide. For example, a patient may require a higher level of care based on the current acuity level or existing medication regimen than what Chelmsford Behavioral Health can deliver.

Additionally,CHelmsford Behavioral Health, LLC may require collateral information from other parties (i.e. schools, other treatment providers) prior to being able to provide treatment recommendations. I understand that by completing the evaluation process it does not mean that Chelmsford Behavioral Health, LLC has assumed responsibility for my care. This will be determined by the provider based on the treatment recommendations.

Appointment Scheduling

After an initial evaluation, it is a standard of the practice to schedule a follow-up appointment within 1 month or sooner, based on the treatment plan. Depending on each patient's psychiatric situation, follow- up appointments could range from every week to every few months. It is expected that patients will be seen at least 4 times per year to remain active in the practice. It is a standard of care by the practice that patients receiving controlled substance prescriptions must be seen on a routine basis, at a minimum of one appointment every 2 months, depending on the prescribed medication.

Cancellations, Missed Appointments, and/or No-Shows

Psychological services are most effective when meeting times are regular and consistent. If I cannot attend my appointment, I understand I must notify the office at least 2 business days in advance to avoid being charged $100 cancellation fee. For example, a patient must notify the provider by Monday at 10 AM if their appointment is Wednesday at 10 AM. I understand that if a cancellation is not made within 2 business days or an appointment is missed without cancellation, I will be charged the full cancellation/no-show fee of $100 for the appointment,and this fee must be paid prior to rescheduling an appointment with my provider.

True emergencies are taken into consideration. Medication refill requests may not be honored if the patient has just missed or canceled one or more appointments.

It is important to note that insurance companies do not provide reimbursement for canceled sessions. In addition, I am responsible for coming to my session on time. Repeated late cancellation of appointments and/or failure to keep scheduled appointments may result in termination from Chelmsford Bhavioral Health, LLC

After Hours

I understand that the provider may not always be available to answer the phone or respond to messages after regular business hours, on weekends, or on holidays. The provider will make every effort to return your call or message within 2 business days . In the event of an urgent situation in which I cannot wait for a return call or in an emergency, I agree to immediately call 911 or go to the nearest emergency room. I must contact my provider after receiving proper emergency assistance so that my provider can be aware of the situation.

Medication Refills Please plan ahead:

1. Each medication refill will be charged $25. Refills will not be provided outside of office hours or on Friday after 3pm, weekends, or holidays. During these hours, I understand I must call my PCP or go to the emergency department to avoid medication discontinuation and withdrawal effects.
2. I am responsible for knowing when medication(s) will need to be refilled and the preferred refill method is to ask my provider during my scheduled office visit.
3. Same day/walk-in refill requests will not be honored. I understand that with each refill request, staff may need to pull my chart, verify current treatments, verify dates, and make medical decisions, all before being able to safely prepare the prescription.
4. If a patient has not been evaluated in 3 months, a follow up visit will be required to verify medication needs. If I am overdue for a visit, my provider may issue enough medication to last until the scheduled appointment. This courtesy refill is at the discretion of the provider and does not apply to all medications.
5. There are strict guidelines for controlled substances including some medications for ADHD and anxiety. These cannot be called for refills. The patient must be seen in the office to obtain a written prescription.

Routine Contact

If I need to contact any of the staff of Chelmsford Behavioral Health for non-urgent matters, I can call during regular business hours. I understand that every effort will be made by the staff to return my call within 2 business days. I am responsible for leaving a message that includes my name and date of birth, explains the nature of the call, and includes information on how to be contacted as well as some available times that I am free to take a call.

I understand that messages asking simply to "speak with the provider," with no other information provided, may not be returned as quickly as a message for a patient stating specific issues they are having, such as medication side-effects or change in mood/ behaviors. I will allow my provider or designated representative to leave messages on my answering machine/voicemail unless I specifically request otherwise, with the understanding that every effort will be made to maintain confidentiality. I understand that most significant medical or psychiatric questions will need a face-to-face appointment to properly evaluate the situation.

Emergencies

In the event of an urgent situation in which I cannot wait for a return call or in an emergency, (i.e. my situation becomes physically unsafe due to a medical emergency or due to dangerous psychiatric symptoms,) I will immediately call 911 or proceed to the nearest emergency room, in order for trained personnel to provide professional emergency services. I will contact my Chelmsford Behavioral Health provider after I have received proper emergency assistance so that my provider can be aware of the situation.

The National Suicide Prevention Lifeline is an excellent resource that provides 24/7, free and confidential support for people in distress, as well as prevention and crisis resources for myself or my loved ones, as well as best practices for professionals. I can reach the National Suicide Prevention Lifeline at 1-800-273-8255.

If I am a patient that requires frequent crisis management, or has a history of requiring this, I realize I may be better served by a more comprehensive service agency that can better address these ongoing issues.

Provider Absence

In the event of the provider's extended absence, the provider will notify the patient and may make appropriate arrangements with regard to any treatment or medication refills. In the event these arrangements require another provider to provide covering services, that provider will have access to my confidential medical information during this time.

Email Contact

I understand email is not appropriate way to handle confidential information or emergencies and that providers of Chelmsford Behavioral Health will not provide any personal or professional email addresses. There will be no electronic communication between patients and providers at Chelmsford Behavioral Health. The office phone and fax are used for all telecommunications. Providers of Health will not provide any personal or professional cellular, "cell", or "mobile" phone number for voice or text messaging contact.

Photocopies

I hereby authorize photocopies and electronic copies of this form to be as valid as the original. The invalidity of any provision of this agreement will not affect the validity of any other provision.

Client Rights and Clinician Duties

I have the right to request restrictions on the disclosure of my protected health information from Chelmsford Behavioral Health. The agency is not required to agree to the restriction requested, but will make every effort to do so, within the legal limits and exceptions of confidentiality. I have the right to request the location at which I receive communications involving protected health information, such as an alternative address or phone number. I have the right to request in writing to examine and/or receive a copy of my records (at a charge of $35,) unless it is determined that access would be a danger to me. In that situation, I have the right to a summary of the record and I can request my record be sent to another mental health provider or to my attorney. I have the right to request an amendment to my record. Chelmsford Behavioral Health may deny this request but can document my concerns in the record. My rights include requesting an accounting of disclosures of protected health information for which I have provided neither consent nor authorization.

Limitations of Chelmsford Behavioral Health, LLC

The providers at Chelmsford Behavioral Health are dedicated to providing the highest level of care for their patients in treating and addressing their mental health needs. However, there are some services not provided in this practice:

- Forensic evaluations for legal purposes
- Custody evaluations, or parental assessments for use in determining custody or visitation
- Disability evaluations, including Short Term Disability and determining leave of absences from work
- Substance Abuse treatment (i.e Suboxone administration)

I understand that it is at the discretion of Chelmsford Behavioral Health providers to provide any evaluation for the purpose of seeking medical or mental disability or to assist in determining ability to take leave from employment.

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Acknowledgment of Practice Policies and Procedures

I have been provided with and agree to the Practice Policies and Procedures of Chelmsford behavioral health, LLC.

Name (Print): _____ Date of Birth: _____

Signature: _____ Date: _____