**Informed Consent for Services**

The Psychiatric Mental Health Nurse Practitioner (PMHNP) will be discussing with you (Patient or parent/guardian) regarding medications to treat your mental health condition. The likelihood of improvement or not improvement from these medications. You are not limited to alternative forms of treatment when agreeing to take these medications. There are several groups of medications used when treating psychiatric conditions and the medications prescribed may belong to one or more of a group that may or may not be FDA approved and may or may not be covered by your insurance.

You will be informed of your medication dosage, frequency, potential side effects, and possible drug dependency associated with certain medications. Medications may be adjusted or changed throughout treatment and you consent to check your prescription history to determine if medication has been discontinued by other providers or if other prescribed medications may interact with medications prescribed. This will also provide information about dosages, amounts and dates of prescriptions you may have received in the past. You have the right to ask for more information at any time should you have further questions or need additional information regarding your medication.

In taking these medications, you understand that you must inform our PMHNP any changes that are made to other medications that you have been prescribed by other physicians/providers, if you wish to change/adjust/stop your medication (s), and any changes to your health conditions. You also understand that you have the right to question, accept or refuse any medication that my provider may want to prescribe. I also understand that my PMHNP reserves the right to refuse my participation in this treatment for any reason including non-compliance with treatment and abusive behavior.

**Telehealth:**

Telemedicine services may be provided upon request and verbal consent from a patient who resides in the state of California. Telemedicine is the use of HIPAA compliant devises permitting two-way, real-time, interactive communication between the patient and Provider at a distant site within the state of California to improve mental health functioning. Consenting to this service means patient consents to telemedicine with his/her Provider as part of the psychiatric treatment. Patient understands that, just like face to face therapy, telemedicine is bound by the laws of the State of California.

Telemedicine includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Patient understands that any risks involving patient's designated location of service is the patient's responsibility. There will be no dissemination of any personal identifiable images or information from the telemedicine interaction to other entities without further written consent, all information transmitted, messages exchanged will be through a secured website that is HIPAA compliant, where sessions are NOT recorded.

Telemedicine has risks and consequences including, but not limited to, the possibility, despite reasonable efforts on the part of the provider, that: the transmission of medical information could be interrupted by unauthorized persons; and/or the electronic storage of medical information could be accessed by unauthorized persons. In addition, telemedicine-based services and care may not be as complete as face-to-face services. However, if the provider believes patient would be better served by face-to-face services, patient will be referred out or provided with such a service. Telemedicine like psychotherapy has potential risks and benefits that despite patient and provider efforts patient's condition may not improve and in some cases may even get worse before they get better. Patient may benefit from telemedicine; however, results cannot be guaranteed. Telehealth services may be provided upon request and consent from patient. You and PMHNP have the right to cancel services at any time.

**Scheduling/Cancellation Policy**

There is a minimum of 24-hour prior notice for cancellations. Any appointments missed without prior cancellation will be subject to a fee. More than 2 missed appointments without prior notification will be subject to termination of services.

**Emergency/Safety**

In an emergency contact, 911, Access 1-800-854-7771, 1-800-SUICIDE, or proceed to the nearest hospital. For Kaiser patients the Behavioral Health Line is 1-800-900-3277. Veteran crisis line is 1-800-273-8255. For your safety and the safety of others, weapons or dangerous objects are not permitted on our premises and we reserve the right to ask that these be removed. Our obligation to provide a safe environment for patient care overrides the patient’s right to privacy.

**Financial obligations**

Psychiatry services are billed to Insurance or made at time of service (e.g. cash patients, co-payments). For cash patients: Payment is made prior to each session and paid at the time of service or in advance. Non-covered service fees may apply for record requests, treatment letters, court appearances, consultation with other entities per patient’s/caregiver’s request and authorization, etc.

As all insurance plans vary there is no guarantee that therapy services will be covered. Should your insurance company decline reimbursement, you are personally responsible for all charges. Therefore, please contact your insurance carrier to ensure coverage prior to receiving services as we cannot ensure coverage due to complexity of some insurance plans. If your account has not been paid for more than 90 days and other arrangements have not been made, there will be late fees and we may take legal action to secure payments, which time, late fee, and legal fee costs will be added to the claim.

**Confidentiality**

Communication between provider and patient are mostly kept confidential except for instances of court subpoena, potential harm to self or others, and child/elder/disabled abuse. Providers are mandated reporters for child/elder/disabled abuse that will need to be reported to appropriate parties. Information can also be released upon patient or parent/guardian’s written consent.

Another disclosure would be required if we should need to provide requested information to insurance companies for billing or continuation of services. Our providers may also consult with other professionals regarding your case as well as with their supervisors for continuation of care, however identifying information will be kept confidential unless legally or professionally mandated. Information can also be provided to seek legal means to collect for unpaid services, however it would only include information that is necessary.

Information may be released without authorization if a request is made by an agent representing the Federal Bureau of Investigation under the Patriot Act (Section 215). Our providers may also consult with other professionals regarding your case, however identifying information will be kept confidential unless legally or professional mandated. If you are a minor, your parents may have rights to access your records and provider would only disclose information that is discussed between us or in cases of high-risk situations, such as self harm or harm to others.

Also minors 12 years old and over have a right to consent to their own services if they are mature and intelligent enough to participate in services in the opinion of the treating professional. Health & Safety Code § 124260.

**Disclaimer of Warranty:**

To the maximum extent permitted by applicable law, Center For Integrated Care is provided “AS IS” without warranties, conditions, representations or guaranties of any kind, either expressed, implied, statutory or otherwise, including but not limited to, any implied warranties or conditions of merchantability, satisfactory quality, title, noninfringement or fitness for a particular purpose. Center For Integrated Care does not warrant the operation of its offerings will be uninterrupted or error free. You bear the entire risk as to the results, quality and performance of the service should the service prove defective. No oral or written information or advice given by Center For Integrated Care authorized representative shall create a warranty. This disclaimer of warranty constitutes an essential part of the Service Agreement.

RIGHT TO ARBITRATE: In order to preserve the integrity and effectiveness of the psychiatric setting, the provider and patient agree that any controversy or claim arising out of, relating to, or resulting in any manner from interpretation of performance of the terms of this therapeutic relationship, will be settled by arbitration in accordance with the prevailing commercial arbitration rules of the American Arbitration Association or its successor, and that the judgment or any award rendered in arbitration will be ﬁnal and binding upon the parties and may be entered in any court having jurisdiction. Arbitration under this provision shall be the sole and exclusive remedy of these parties. Patient will submit a written request to arbitrate any such controversy or claim in accordance with the rules within six months of the event giving rise to the controversy, or the right to arbitrate any claim in connection with such controversy is waived.

**Appeals and Grievances:**

Patient understands that you have the right to request reconsideration or transfer of provider that can be made through your insurance or directly to the Center and that you risk nothing in exercising that right. Grievance forms/contact information can also be provided for your respective insurance carrier. You can submit your complaint/grievance to Center For Integrated Care at any time by contacting our center at 323-879-9176.

**Receipt of Privacy Practices**

I acknowledge receipt of the HIPPA Notice of Privacy Practices by initializing here \_\_\_\_\_\_\_\_\_\_.

I consent to email/text communication that is limited to scheduling, inquiry of services, billing, administrative items, and coordination of care and I understand the risks that not all electronic communication is secure, private, confidential, and safety cannot be guaranteed. Initials\_\_\_\_\_\_\_.

**I have read the above Agreement and Informed Consent for Services and I fully understand the terms and conditions and agree to comply with them as signed below. I also consent to take the medication(s) as prescribed.**

**This form was translated into \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and accepted/declined a copy.**

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**Patient name**

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**Patient signature/Parent (Guardian) Name and Signature/Date**

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**Provider Signature/Date**