**Informed Consent for Psychiatric Mental Health Treatment**New Journey Psychiatry

59 Merriam Avenue

Leominster, MA 01453

(508) 887 1843

This Informed Consent is not intended to be all inclusive for aspects of your behavioral health treatment. It is only intended to provide some useful information before deciding to engage in behavioral health treatment.

**Mental Health Services**New Journey Psychiatry recognizes that it may not be easy to seek help from a mental health professional and taking the first step is the most important. Many don't know what to expect from a psychiatric prescriber. At New Journey Psychiatry (NJP) the Psychiatric Mental Health Nurse Practitioner(PMHNP/NP) will evaluate, diagnosis and treat different mental health illness. They will strive to assist your growth towards greater health and wholeness by providing medication services within a biopsychosocial framework. Though NPs with NJP do not offer therapy services it is strongly recommended that clients also meet with a therapist regularly. **Appointments and Cancellations**Appointments are made through the patient portal, on the website or by calling the office. Please leave a message with your name, purpose of your call, and a call back number and someone will get back to you within 72 hours. Please call to cancel or reschedule at least 24 hours in advance. Third-party payments will not usually cover reimburse for missed appointments. **Medication Refill Requests**

Refills are managed at every follow up appointment. If you have missed an appointment or need a refill for some reason in-between visits, please request refills through the patient portal or through NJP’s email. Allow up to four days for the refill to be sent.

**Payment for Services**

If you have insurance, different copayments are required by various group coverage plans. Your copayment is based on Mental Health Policy selected by your employer or purchased by you. You are responsible for and shall pay your copay portion of New Journey Psychiatry charges for services. You are responsible for notifying NJP immediately of any changes to your insurance. If you fail to notify NJP of any changes to insurance, you may be billed for services that are not covered. ​NJP will look to you for full payment of your account, and you will be responsible for payment of all charges.

**Relationship**Your relationship with the NP is a professional and therapeutic relationship. To preserve this relationship, it is imperative that the practitioner not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The practitioner cares about helping you but is not able to be your friend or to have a social and personal relationship with you. **Duty to Warn**If the NP reasonably believes that the client is in danger, physically or emotionally, to themselves or another person, consent is given to warn the person in danger and to contact any person in a position to prevent harm to themselves or another person, including law enforcement and medical personnel. This authorization shall expire upon the termination of therapy.**Goals, Purposes, and Techniques of Therapy**The number one treatment modality for all mental health disorders is therapy. Medication is meant to be an augmentation of treatment that supports a client biologically. The goal of medication management is not to make all symptoms go away, but to enable the client to have an improved quality of life. Medications will be discussed as a team and chosen based on a person’s individual needs.

**Pediatric Population**

For children of divorced or separated parents, if there is disagreement between the parents this must be discussed at the first session. The parent requesting or arranging services, must have the legal right to authorize care and treatment of the child, and will be responsible for payment. Documentation of legal agreements may be required. Our services billed as medical services are focused on treating the presenting mental or substance use issues and not focused on assessing parenting capacity or documenting disputes between parents.

**After-Hour Emergencies**Emergencies are defined as urgent issues requiring immediate action. I​f you are experiencing a psychiatric or medical emergency and reach the business after hours, call or report to your local emergency room immediately. O​ther national resources include, but are not limited to: S​uicide Prevention Hotline 988/1-800-273-8255; M​H Warm Line, (866) 854-8114; ​​Suicide Prevention Text Services: text 741741;​ h​ttps://suicidepreventionlifeline.org/​; ​<http://www.yourlifeyourvoice.org> IN CASE OF A MEDICAL EMERGENCY, DO NOT USE EMAIL OR TEXT. CALL 911

**Contact Information**NJP offers clients the opportunity to receive text reminders in place of phone reminders. This provides the guidelines regarding text reminders. NJP uses a secure encrypted server to send information to you that offers a level of security. Once a text is on your phone it is your responsibility to who may have access to that text. Clients agree to notify NJP immediately if their text number changes.

**Text Messaging and Emails**

NJP cannot, and does not, guarantee the privacy, security or confidentiality of any text messages sent or received. NJP is not responsible for text messages that are lost due to technical failure during composition, transmission, or storage. NJP offers clients the opportunity to receive email reminders in place of phone reminders. Once an email is sent it is your responsibility for who may have access to that email. Email use is for NJP to send clients emails with appointment information. Clients agree to notify NJP immediately if the email address changes.

By signing the Informed Consent and Privacy Practices Receipt, you are consenting for NJP to communicate with you by mail, e-mail, and phone at the address and numbers provided at the initial appointment, and you will immediately advise NJP in the event of any change. You agree to notify NJP if you need to opt out of any form of communication. **Confidentiality**

Discussions between the NP and client are confidential. No information will be released without the client’s written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases, suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist’s judgment, it is necessary to warn, notify, or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with a licensing board or other state or federal regulatory authority.If you have any questions regarding confidentiality, you should bring them to the attention of the NP. By signing this form, you are giving consent to New Journey Psychiatry to share confidential information with all persons mandated by law, with the agency that referred you, and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services. You are also releasing and holding harmless New Journey Psychiatry from any departure from your right to confidentiality that may result.

**Consent to Treatment**By signing this form means you also voluntarily agree to receive mental health assessment, care, treatment or services and authorize NJP to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment or services at any time. By signing you acknowledge that you have both read and understood all the terms and information contained herein. Ample opportunity has been offered for you to ask questions and seek clarification of anything that remains unclear.

**General Consent for Care and Medical Treatment**You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your prescriber about the purpose, potential risks and benefits of any medication prescribed or test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Client Name Print \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_