INFORMED CONSENT FOR SERVICES

Please read and sign at the end stating you have fully read and understand the information below.

AVAILABLE SERVICES: Elements of Motivation offers a wide array of short-term mental health services, including individual therapy, family therapy, couples therapy, group services, Psychosocial Rehabilitation and Basic Skills Training to address many of the issues our clients are dealing with. Your first visit will be an intake session in which you and your Therapist will determine your concerns, and if both agree that he/she can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your Therapist, services to you may be terminated.

The goal of Elements of Motivation is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if transferring to a more suitable Therapist is right for you. If you and your Therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

We are staffed by skilled and experienced licensed therapists, counselors and psychologists, licensed intern therapists and counselors and rehabilitative support staff. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 – 120 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist. If you must cancel or reschedule your appointment, we ask that you call our office at least 24 hours in advance, whenever possible. This will free your appointment time for another client.

RISKS AND BENEFITS: Counseling, psychotherapy and support services are beneficial, but as with any treatment, there are inherent risks. You will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, Elements of Motivation will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Monthly payment arrangements are available, if needed, for clients who have established a payment record for three months. **You are responsible for any fees not covered by insurance.**

> **Regarding copays/coinsurance**: A copay is a fixed amount outlined in your insurance policy that the client pays each time a covered service is provided. A co-insurance is a percentage outlined in your insurance policy that the client pays each time a covered service is provided. Your copay/coinsurance amount is only an estimate based on the information available online, provided by the payer. The total listed on your invoice may vary from what is initially quoted to you.
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> **Regarding deductibles**: A deductible is the amount you must pay out of pocket for covered expenses before the insurance company will cover the remaining costs. If you have a deductible, the amount you pay for your covered service will depend on whether or not this deductible has been met. If it has not been met, it is typical for the amount paid to be higher. If it has been met, it is typical for the amount paid to be lower. This means that you will pay different amounts over the course of time in utilizing our services.

Elements of Motivation will work to ensure the most accurate estimates of both co-pays and deductibles with the information available at the time of service.

Please list your insurance information:

Primary insurance:_____

Additional/other insurance:_____

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When your Therapist is out of town, you will be advised and given the name of the on-call therapist.

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONFIDENTIALITY: Elements of Motivation follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your services. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a 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 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 the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

When conducting therapeutic services in locations other than the office (e.g. client homes, medical/rehab facilities, et al), there exists potential for limitations to confidentiality. These limitations occur due to aspects of the environment which are outside of either the clinician's or client's control, and may include, but are not limited to:

- Family members/medical staff/others entering or passing through the area where therapeutic services are conducted
- Individuals in close proximity (e.g. neighbors, family, roommates, medical staff, et al) overhearing dialogue and concepts which arise or are presented during session via open windows, doors, etc.

Both the clinician and client will work to explore and utilize the most private location available within reason to conduct therapeutic services in accordance with state and federal laws, however even in light of these considerations, there are situations where confidentiality cannot be reliably guaranteed.

LETTERS: Therapists may be able to provide a letter for the purposes of an Emotional Support Animal, Gender Affirming Surgery, etc. If a letter is required attesting the client's needs the therapist may provide it for a fee of $45 per one-page letter and $35 for each additional page. Letters are only provided to clients who have been seen for 8 sessions or longer. Due to the ethical limits and boundaries placed on therapists for writing such letters, please consult directly with the therapist about their willingness or ability to provide you with the requested letter.

RECORDING: Unless otherwise agreed to by all parties beforehand, we will not audio or video record therapy sessions, phone calls or any other services. The client is prohibited from recording sessions, phone calls or any other services without the consent of the therapist. Violation of this policy may result in termination of services.

RECORDS: Nevada Revised Statute 629.051 requires that custodian's of health care records shall retain the health care records of patients for 5 years after their receipt or production, regardless of the format which includes electronic formats. For minors, these records are maintained until the client has reached age 23, regardless of the age the records were received or produced.
Please Note: After this 5 year period for adults, health care records may be destroyed. For minors, once age 23 has been reached, health care records may be destroyed.

RECORDS REQUESTS/RETRIEVAL: Nevada Revised Statute 433.504 entitles consumers or the consumers' legal guardian to the acquisition and fees associated with the reproduction of records, should they be requested. Please see below for retrieval fees:

Requesting Party	**Retrieval Fee**	**Per Page Fee**
Client*	$15	$.75
Social Security Disability	$15	$.75
Workers Compensation	$15	$.75
Other Organizations	$15	$.75

*Should the client request their records for the purpose of reviewing current medical care, there is no fee.

COURT APPEARANCES: It is not recommended that clients have their therapist subpoenaed. Although the client's attorney is responsible for the initiation of the subpoena and the fees related to the court appearance, testimony, and retainer of the therapist, the testimony of the therapist may not assuredly be in the client's favor. Therapists do not have the expertise or necessary training for effectively navigating the legal landscape or to ensure that the testimony would not have serious/damaging ramifications for the client's legal outcomes. Please see below for fees applying to court appearances:

Preparation time (including record submission)	$250/Hour
Phone calls	$250/Hour
Depositions	$280/Hour
Email/Written Letters	$220/Hour
Time Required in Giving Testimony	$280/Hour
Mileage	$.75/Mile
Time away from current work schedule	$250/Hour
Single document filing with the court	$120 (plus court fees)
Minimum charge for court appearance	$1,500
Any/all legal fees/costs incurred by the therapies as a result of legal action	Varies

Please note: A $1,500 retainer is due 5 business days in advance. If the subpoena/notice to meet attorney(s) is received without a minimum of 5 business day notice, there will be an additional $280 “late notice” fee. If the case is reset with notice of less than 72 business-hours, the client will be charged $550 (in addition to the retainer of $1500). All fees are doubled if the therapist has to postpone or interrupt plans to go out of town.

*Fees are subject to change without notice. Please call to confirm the latest fee schedule.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name _____ Telephone Number _____

EMERGENCY CONTACT: In the event of an emergency during a session or while you are on the premises of Elements of Motivation, we may need to contact someone on your behalf. Please provide the following emergency contact information:

Emergency Contact Name: _____

Phone Number: _____

Relationship to Client: _____

By providing this information, you authorize our agency to contact the individual listed above in case of an emergency. This information will only be used in such situations and will remain confidential according to our privacy policy.

TELEHEALTH: Telehealth involves the use of electronic communications to enable Elements of Motivation clinicians to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Elements of Motivation utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth via ZOOM for Healthcare or Doxy.me.

4. Clinicians follow the State of Nevada Regulations for tele-health as well as their respective board regulations and ethics. They have also received training to provide telehealth services.

5. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services: Elements of Motivation will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. The standard copay and/or deductibles would apply. In the event that insurance does not cover telehealth, you may wish to pay out-of-pocket, or when there is no insurance coverage. We can provide you with a statement of service to submit to your insurance company.

CONSENT TO TREATMENT

By signing this Informed Consent for Services as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form regarding traditional and telehealth services.

I have been given an appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I have read this document carefully and understand the risks and benefits related to the use of traditional and telehealth services and have had my questions regarding the procedure explained. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Elements of Motivation will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

_____ _____ _____

Name of Client/Parent/Guardian Signature of Client/Parent/Guardian Date

_____ Client DOB: _____

Name of Minor Client

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____ _____

Signature of Client/Parent/Guardian Date

I hereby authorize the payment of medical benefits to the provider of services.

_____ _____

Signature of Client/Parent/Guardian Date

CONSENT TO USE PHI FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

With my consent, Elements of Motivation may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Elements of Motivation Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Elements of Motivation reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Elements of Motivation at 7040 Laredo St. Ste K. Las Vegas, NV 89117.

With my consent, Elements of Motivation may call my cell phone or designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care. With my consent, Elements of Motivation may mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential.

With my consent, Elements of Motivation may email to me my appointment reminder cards and patient statements. I have the right to request that Elements of Motivation restrict how it uses or discloses my PHI to carry out TPO. However, the practice is required by state statutes to agree to my requested restrictions, unless in extenuating circumstances allowed by law.

By signing this form, I consent for Elements of Motivation to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Elements of Motivation may decline to provide treatment to me.

_____	_____	_____
Name of Client/Parent/Guardian	Signature of Client/Parent/Guardian	Date
Marcio Rezende	_____	_____
Name of Staff Member	Signature of Staff Member	Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE & DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or

arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	Judicial and Administrative Proceedings
Emergencies	Law Enforcement
National Security	Public Safety (Duty to Warn)

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 702-331-4874

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in

those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost based fee for copies.

- **Right to Amend**. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification**. If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself
- **Right to a Copy of this Notice**. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Diana Saunders, at 702-331-4874 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. ***We will not retaliate against you for filing a complaint.***

The effective date of this Notice is 5/8/2020.

RECEIPT AND ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Client Name: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Elements of Motivation Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at 702.331.4874.

_____ _____

Signature of Client/Parent/Guardian Date

Or Personal Representative*_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

__Marcio Rezende_____ _____ _____

Name of Staff Member Signature of Staff Member Date