INNOVATIVE BEHAVIORAL MEDICINE LLC

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Silver Spring, MD 20910
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CONSENT TO TREATMENT

Purpose

The purpose of this form is to inform you of the policies of this practice and its expectations of you as a patient so that you can make an informed decision of whether or not you want to obtain care from it. After reading this form, please initial where indicated; sign and date the last page; then schedule your appointment. A signature indicates that you have read and understand the information contained herein and agree to the same.

RISKS AND BENEFITS OF PSYCHOTHERAPY TREATMENT

Although psychotherapy and psychiatric diagnostic services have been demonstrated to be safe and effective procedures, clients may experience transient discomfort in the course of psychotherapy or diagnostic testing associated with working through difficult emotions, events, or historical material. A small number of clients may not improve as a result of therapy or may terminate before it is clinically indicated. It is important to keep your therapist/psychiatrist advised of any difficulty you may encounter in the course of your treatment or if you have any concerns about your treatment plan and progress.

Client Initials________

Innovative Behavioral Medicine LLC

Outpatient Treatment Consent

- I understand outpatient treatment consists of regularly scheduled appointments.

- I understand it is my responsibility to attend each appointment or reschedule in a timely manner.

- I understand it is also my responsibility to follow the recommendations of my provider and failure to do so is cause for discharge from treatment.

- I understand that these are voluntary services that I may discontinue at any time.

- I give my full permission to be treated by Innovative Behavioral Medicine LLC.

- I give my full permission Innovative Behavioral Medicine LLC to disclose all information needed or required by my insurer to facilitate billing for services provided.

Signature_________________________ **Date:**_______________

If patient is a minor or unable to sign, then patient's guardian or personal representative should sign.

Innovative Behavioral Medicine LLC

The following are some regulations that specifically apply to your treatment:

- All patients have the right to have equitable access to treatment regardless of race, religion, sex, ethnicity, age or handicap.
- All patients are treated with politeness, respect and care from all the staff, and we expect the same from you.
- All treatment is completely confidential in accordance with the medical records law; state and federal regulations. No information will be released without prior written consent except in the following conditions:
    - To report suspected physical, sexual abuse or criminal activities.
    - To report intent of homicidal intentions to the identified victims and authorities notified.
    - To report suicidal intentions to your family and hospitalization considered.
- The lead clinician reserves the right to terminate therapy due to the patient's failure to comply with treatment recommendations and/or failed appointments.
- One of the treatment modalities is prescribing psychotropic medication that can cause some side effects. This will be discussed and explained to you.
- You have the right to accept or refuse treatment.
- Access to medical records should be discussed on individual cases with lead clinician due to the sensitive issues that might be documented in the records.
- Upon receipt of written consent, medical records might be released to a third party or directly to a requested provider.

Signature______________________________ **Date**___________

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FINANCIAL AND INSURANCE AGREEMENT

- Any amount not paid by your primary insurance company is your responsibility, including deductibles, copayments, and denied claims.
- It is your responsibility to understand which services are covered by your policy and which are not.
- You are also accountable to ensure that you do not exceed the yearly maximum number of visits allowed, if applicable to your insurance.
- This office will bill secondary insurance if we are given the insurance information needed to do so.
- If any insurance information is given to us after previous office visits have occurred, it may be too late to retroactively bill your insurance carrier, even if your insurance was effective when the visit occurred.
- Any applicable co-payment, co-insurance, or deductible must be paid prior to your session or you may not be seen for your appointment.

Do you have health insurance?_______ ▾

Primary Insurance

If yes, what is the name of your insurance?__________________________ ▾ Plan____________________ Group# _______________

Are you the subscriber? ___ ▾ If no, provide subscriber's name__________________________ Subscriber's DOB:________________

Relation to subscriber______________________ ▾ Subscriber's Employer (if applicable):__________________________________

Secondary Insurance

Do you have secondary insurance?_____________ ▾

If yes, what is the name of your insurance?__________________________ ▾ Plan____________________ Group#________________

Are you the subscriber?___ ▾ If no, provide subscriber's name__________________________ Subscriber's DOB:_________________

Pharmacy Information:

What is the name of your preferred pharmacy?__________________________________ Phone #:_____________________________

Address____ City_______________________ State _____ Zipcode ______________

Signature_________________________ **Date**_____________

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Cancellations/Payment Agreement

NO SHOWS AND CANCELLATIONS:

A notice of 48 business hours is required for the cancellation of any appointment. You must cancel via telephone (if no answer or after business hours, leave a voicemail). An example of a late cancellation is as follows: A patient has an appointment at 2:00 P.M. and calls on the previous day at 6:00 p.m., when the cancellation should have been made by 2:00 p.m. the previous day). Failure to give a minimum of 48 business hours notice will result in a fee of $60 (initial consultations are $100). If you give a notice within 24 hours of your cancellation you will be charged a $40 late cancellation fee (initial consultations are $100). If you are a no-show for a scheduled appointment, the fee is $100 ($200 for an initial consultation. Two or more no show/late canceled appointments may result in discharge from this practice at the discretion of your provider. This fee will automatically be charged to a patient's credit card or checking account on-file without notification as this consent serves as notification in the event of a late cancellation or no show.

Client Initials:________

NO REFUNDS

There will be no refund for out-of-pocket co-payments or insurance payments received for services rendered. Client Initials:_____

RETURNED CHECKS/DECLINED ACH DEBIT OR CREDIT CARD

A fee of $25 will be charged to your account for a check returned or ACH debit/credit card declined. Client Initials:_______

FORM FEE

There is a $50 per every 15 minutes charge for each form that the provider is asked to fill out (Short term disability, Long term disability, FMLA, Social Security Disability, Worker's Compensation, Driver's License form, etc.). We will not fill out any forms until you have been a patient at this practice for at least six months.

Client Initials:_______

PRESCRIPTION REFILL PRIOR TO APPOINTMENT FEE

There will be a $25 fee if you miss/cancel your appointment or forget to schedule an appointment but are requesting a refill request. If the medication is refilled, you will be required to schedule an appointment no later than 10 days from the date your prescription was refilled.

Client Initials:_______

By signing I am acknowledging receipt of:

I read and understand the Consent for treatment.
I read and understand the Financial Agreement.
I read and understand the Late Cancellation/No Show Policy

Client Signature:________________________________ **Date:**_______________

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HIPPA Agreement

As required by the Health Insurance Portability and Accountability Act (HIPPA), Innovative Behavioral Medicine LLC does not share your protected health information (PHI) and/or health records without your consent. Except for billing purposes, Innovative Behavioral Medicine LLC shall not disclose, sell, transfer, or provide any PHI, or other confidential information about you to any third party. Your privacy is important to us, as are your rights. In order to ensure that your records are properly protected, we need to have written authorization for disclosure of your records. If you wish your records or PHI be disclosed to third parties, ask to complete and execute an authorization to release information form, which will be valid for up to one (1) year from the date of execution.

Notice of CRISP Privacy Practices

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange to provide faster access, better coordination of care, and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Client Signature:________________________________ Date:__________________

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Medication Management Agreement

To provide the best quality psychiatric care to our consumers, there will be an agreement between the consumers and the Psychiatrist/Practitioners regarding controlled substances.

By signing, the patient asserts that all of the following statements are true:

- I understand that the main treatment goal in prescribing controlled substances is to improve my ability to function and/or work. In consideration of these goals, I agree to help myself by following better health habits including but not limited to exercise, eating healthy and avoiding the use of alcohol and tobacco. **Client Initials**________
- I am responsible for my controlled substance medication. If the prescription medication is lost, misplaced, stolen or if I need it refilled sooner than prescribed, I understand it will NEVER be replaced. **Client Initials** _______
- I will not request or accept the same class of medication from any other physician/prescriber. **Client Initials** ________
- Refills of medications will only occur at scheduled medication check appointments. Refills will not occur over the phone.

  Client Initials __________
- Refills will not be authorized early because of vacations or personal plans. **Client Initials** ________
- I am responsible for taking my medication at the dose and time prescribed. **Client Initials** _________
- I will not share, trade, or sell my medications. I understand that doing so will result in my immediate discharge from this office. **Client Initials** ________
- I will disclose fully to the best of my knowledge all other medications I am taking, including methadone. **Client Initials** ________
- I agree to comply with random urine or blood testing. **Client Initials** _________
- I understand that driving a motor vehicle may not be allowed at times while I am taking a controlled substance and it is my responsibility to comply with the laws of this state and in accordance with my prescriber. **Client Initials** __________
- I understand that if any criminal charges for receiving, possession or selling of illegal substances and/or a controlled substance prescription will be reviewed by my prescriber and may result in my discharge. **Client Initials** __________
- I understand that combining a benzodiazepine (Valium, Xanax, Klonopin, and Ativan) with an opiate medications (heroin, Vicodin, Percocet, Morphine), Alcohol, and Barbituates can cause respiratory depression and possibly death. **Client Initials** ______

I, the undersigned, agree to follow these guidelines that have been fully explained to me. All questions and concerns regarding this form and my treatment have been adequately answered. If I do not follow these guidelines, Innovative Behavioral Medicine LLC has the right to taper and/or discontinue my medication and discharge me from this office with alternative referrals.

Client Signature _____________________________ **Date:**____________________

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Distance Counseling Agreement

Purpose

This document is designed to inform you about many aspects of distance counseling including what to expect; potential benefits and risks; safeguards against those risks; alternatives to distance counseling; and other essential considerations. It is important to be aware that there is an increased risk for misunderstanding when using telephone, text-based modalities such as email, real-time internet chat, or video conferencing since many of the non-verbal cues are significantly reduced. When using video conferencing software, misunderstandings may occur since bandwidth is always limited and images can lack detail. Counselors are observers of human behavior and gather much information from body language, vocal inflection, eye contact, and other non-verbal cues. If you have never engaged in distance counseling before, please have patience with the process and provide clarification if you think your counselor has not fully understood you. We also ask that you be patient if your counselor periodically asks for clarification as well.

Privacy of the client and the counselor

Although the internet provides the appearance of anonymity and privacy in counseling, privacy in distance counseling presents some unique challenges. The client is responsible for securing their own computer hardware, internet access points, chat software, email and passwords. The counselor has a right to his or her privacy and may wish to restrict the use of any copies or recordings the client makes of their communications. Clients must seek the permission of the counselor before recording any portion of the session and/or posting any portion of said sessions on internet websites such as Facebook or YouTube.

Potential benefits and risks of distance counseling

- **Potential Benefits**
  - Convenience of receiving counseling from any locale as long as you, the client, can obtain an internet signal and operate the necessary hardware;
  - Increased client anonymity by removing common indicators that one is receiving counseling services (ex. car parked outside of the counseling center);
  - Increased flexibility in scheduling sessions;
  - Lack of disruption to the regular counseling process due to inclement weather or due to the client being out of town on vacation or business;
  - Increased availability of counseling services for clients with difficulty accessing a brick and mortar counseling site.

- **Potential Risks**
  - Email messages not being received and can be compromised or hacked; patients send emails at their own risk.
  - Possible denial of insurance benefits (check with your insurance company to determine coverage);
  - Confidentiality being breached through unencrypted email, lack of password protection; or leaving information on a public access computer in a library or internet café.
  - Messages could fail to be received if they are sent to the wrong address (which might also be a breach of confidentiality).
  - Confidentiality could be breached in transit by hackers or internet service providers or at either end by others with access to the client's account or computer.
  - People accessing the internet from public locations such as a library, computer lab or café should consider the visibility of their screen to people around them.
    - Position yourself to avoid peeping by those around you.
    - Using cell phones can be risky in that signals are scrambled but rarely encrypted.

Safeguards

Innovative Behavioral Medicine LLC utilizes Valant Telemedicine or Doxy, the world's largest platform for telemedicine. Doxy offers videoconferencing technology and provides the highest possible security and confidentiality for the content of your sessions. Your personal information is encrypted and stored on a secure server. The client is responsible for creating and using additional safeguards when the computer used to access services may be accessed by others, such as creatingpasswords to use the computer, keeping one's email and passwords secret, and maintaining security of their wireless email and Passwords secret, and maintaining security of their wireless internet access points (where applicable). Please discuss any such concerns with your counselor early in your first session in order to develop strategies that minimize risk.

Client Initials:____________

Distance Counseling Agreement (continued)

Alternatives

Distance counseling may not be appropriate for many types of clients including those who have numerous concerns over the risks of distance counseling, clients with active suicidal/homicidal thoughts, and clients who are experiencing active manic/psychotic symptoms. If your counselor assesses that distance counseling may be harmful or ineffective, a referral to a local provider will be rendered on your behalf. An alternative to receiving mental health services online would be receiving these services in person. The distance counselor can and will assist clients. who would like to explore face-to-face options in their local area. Many state and local agencies will treat low-income clients on a low or no-fee basis. Please feel free to request a referral anytime you think a different counseling relationship would be more practical or beneficial for you.

Provider/Counselor

Your provider will take extraordinary care and consideration to prevent unnecessary disclosure. Information about the client will only be released with his/her permission. However, there are some important exceptions to be aware of including:

- If a provier believes that someone is seriously considering and likely to attempt suicide.

- If a provider believes that someone is an imminent threat of harm to another person.

- If a provider believes someone is engaging/intends to engage in behavior which will expose another person to a potentially life-threatening communicable disease.

- If a provider suspects abuse, neglect, or exploitation of a minor, incapacitated adult, or elder adult.

- If a provider believes that someone's mental condition leaves the person gravely disabled.

Records

The provider will maintain records of online sessions inclusive of reference notes, copies of chat transcripts, and internet communication and session summaries. These records are confidential and will be maintained for seven years as required by applicable legal and ethical standards according to the American Counseling Association. The client will be asked in advance for permission before any audio or video recording will occur on the counselor's end.

Procedures

The provider might not immediately receive an online communication or might experience a local backup. If the client is in a state of crisis or emergency, the provider recommends contacting a crisis line or an agency local to the client. Additionally, if the provider has legitimate concern about the safety of you, the client, and the distance session is disrupted without a plan in place, the provider will send out crisis responders to your location to complete a safety assessment.

In order to effectively carry out this plan, your provider will ask for your location at the start of each session to verify your whereabouts. Clients may utilize the following crisis hotlines:

- 1-800-SUICIDE 1-800-273-TALK For the Deaf: 1-800-799-4TTY

Work with your provider to identify local resources if you have concerns about the timeliness of responses.

Client Initials______

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Distance Counseling Agreement (continued)

Disconnection of Services

If there is ever a disruption of services on the internet, then the client will need to call Innovative Behavioral Medicine's main line at 301-615-8752.

Physical Location of Practice

801 Wayne Ave
Suite G100
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Social Media Policy

In order to promote the highest level of quality care, your counselor is committed to establishing and maintaining a professional relationship with clearly defined boundaries. Your counselor will respect your privacy and presence on social media by not viewing such information unless given prior consent. Moreover, counselors will not accept friend requests to their personal social media accounts in order to minimize the risk for client exploitation.

Client Verification

In the first session the client and counselor will agree upon a code word, number, graphic or other nondescript identifier in order to prepare for instances in which the counselor is unable to verify the identity of the client due to technological difficulties with videoconferencing software.

Client Signature ________________________ **Date** 09/17/2021