MIND Therapy CLINIC

INNOVATIVE MEDICINE, PERSONALIZED CARE

Welcome!

We appreciate the confidence you have placed in us, and look forward to serving your child's psychiatric needs. We are aware you have options in pursuing psychiatric care and want you to know we are dedicated to providing the highest quality care.

With all of the many administrative and legal demands on the practice of medicine, our office has developed policies and procedures that enable us to continue serving our clients at the highest level of care.

Our hope is that in reading the enclosed information, you will further understand how to navigate the complicated medical world as it relates to your time in our care. Please take the time to read them carefully and should you have any questions or concerns we would be happy to take the time to talk with you at our first meeting.

Thank you in advance for your attention to the enclosed information, but most of all, for your trust and confidence in choosing Mind Therapy Clinic to provide your care. We look forward to meeting you.

Sincerely,

Your Care Team at Mind Therapy Clinic

POLICIES

Appointments
Appointments are generally scheduled for half-hour, hour, and one and a half hour time periods. This includes 20, 50, and 80 minutes of face-to-face time with a clinician, and 10 minutes in which the clinician completes charts, paperwork and phone calls. We make an effort to stay on schedule to be fair to everyone and provide the best service.

It is important for you to be on time for your appointment and to complete all paperwork a at initial visits, as your appointment will still need to end on schedule. Lateness may require scheduling an additional appointment to complete necessary work.

Paperwork
Our paperwork is available on-line. We can also send out paperwork to you by mail after you schedule the initial appointment so you have time to gather all appropriate information before your first visit. The completion of these forms before you come to our office is of great importance. It is imperative that we have your clinical data and exact medication history in order for us to address your needs. By having your history completed beforehand, we are able to spend our limited time together in the most effective and efficient manner. We understand that there is a lot of information we are asking for and we appreciate your efforts to provide us with a thorough and accurate history. Incomplete paperwork may prevent us from completing the initial evaluation in one session and may require that you return again to complete the appointment. Please complete the whole package before your appointment and bring it with you.

Prescription Refills
Typically, your provider writes prescriptions for the amount of medication needed until your next scheduled appointment. Patients who require refills should request their pharmacies to send an electronic or fax request for refills to our office. Please make this request at least **five (5) business day**s prior to running out of medication. Please call for refills during regular office hours.

Cancellation Policy
We require **two (2) business days** notice on all cancellations except for medication management appointments. We require **one (1) business day** notice on medication management appointments. **Two (2) weeks notice** must be given when cancelling ongoing enrollment in any group. In our paperwork you sign an agreement regarding appointments that are late, cancelled late or missed for any reason. **It is our policy that the time lost by the clinician, not the reason for the cancellation, is what determines a charge.**

Insurance
Mind Therapy Clinic is a fee-for-service practice. As such, we do not contract with any insurance plans. While this may seem unusual for many, we feel that this is in the best interests of our patients. Medical care should be a partnership between a patient and a physician or other clinician. Insurance companies often try to influence and control the nature of the care

provided. They frequently place unreasonable constraints on treatment options and even the amount of time that clinicians spend with patients.

In addition, accepting insurance would require greater administrative resources that detract from the time that our clinicians can spend with their patients. In particular, given our comprehensive, integrative treatment plans, we would find ourselves spending too much time attempting to obtain insurance approval for each of the treatment options.

Non-visit Charges
We are frequently asked to call insurers, call for prior authorization for medications, prepare letters and reports, and other services outside of regular appointments. We are happy to do so. However, many of these services can take a considerable amount of time. For instance a call to an insurer for prior authorization for a medication can often take as much as twenty minutes.
For any such services requiring more than about five minutes of a clinician's time, you will be charged based upon the amount of time spent by the clinician.

Non-Covered Charges
A statement of charges and payments will be provided to you. This statement will be coded so you may submit it to your insurance carrier for possible reimbursement. Please realize that some charges for services may not be covered by your insurance policy. These may include, but are not limited to: some diagnostic testing; neurofeedback treatment; some telephone calls or emails to a patient for consultation or medical management; intervention for medical management purposes on a patient's behalf with agencies, employers or insurance companies, including preauthorization for non-formulary medications; psychiatric evaluation of records, reports and other data for medical persons; preparation of reports for other physicians, agencies, insurance carriers, or attorneys; and missed appointment fees that are not covered by insurance.

Communication with Other Clinicians
We have found it is a helpful and important component of mental health care that we communicate and coordinate with other healthcare professionals involved in your care, particularly psychotherapists and primary care physicians. To do this, we need you to sign the attached Consent for Release of Confidential Information to Primary Care Physicians and/or Referring Practitioners.

Our service to you is important to us. We appreciate respectful and constructive feedback and look forward to working together with you.

PATIENT ACKNOWLEDGEMENTS

We have found it helpful to outline our office policies in writing. Please take a few moments to review the following information and ask us any questions you may have.

CANCELLATION POLICY

Scheduled appointment times are reserved for you. All appointments are subject to full charge, whether missed, unattended or cancelled. This charge can be avoided by giving 2 business days' notice. In order to avoid being charged the full amount of the appointment you must call by 5 p.m. at least 2 business days prior to the appointment day (i.e., if your appointment is anytime on Monday you must call to cancel by 5 p.m. on the prior Thursday). Medication management visits require only 1 business day's notice. We charge on a monthly basis for group therapy at the time of enrollment and two weeks' notice must be given when cancelling enrollment in any group. Missed group sessions are not refunded. It is our policy that the time lost, not the reason, is what determines a charge. Please note that insurance companies do not pay for cancellation fees and, therefore, these charges will be your responsibility. Repeated "no show" appointments could result in treatment ending for non-compliance

(Initial)_____

RETURNED CHECKS

There will be a $35.00 service charge applied to your account for all returned checks.

DELINQUENT ACCOUNTS

Should your account become 60 days delinquent, finance charges of one and one half percent (1.5%) per month may be added to your bill. Services may be discontinued and your bill may be turned over to a collection agency if your account becomes delinquent. Should that happen, you will be responsible for payment of all legal and all other collection costs.

(Initial)_____

LIMITS OF CONFIDENTIALITY STATEMENT

Information obtained by Mind Therapy Clinic relating to the client is strictly confidential. Mind Therapy Clinic clinicians share confidential mental health information only with other healthcare providers involved in the client's treatment in order to provide integrated, comprehensive care. There are legal exceptions to when such information may be shared with third parties, such as (1) in medical emergencies; (2) if the client presents as a physical danger to self or others; (3) if child or elder abuse and/or neglect is suspected; or (4) if the client authorizes the release of the information with a signature. For more information on how health information may be used or disclosed by Mind Therapy Clinic, please refer to our Notice of Privacy Practices.

(Initial)____

CELL PHONES, INSTANT MESSAGES, FAXES, EMAIL, VIDEO CHATS

It is important to note that cell phone, instant messages, video chats, and email communication may not be secure. Faxes can also be easily sent to erroneous numbers. If you are using a cell phone while communicating with our office, you must be aware that we cannot ensure the confidentiality of the call. If you use email to communicate with Mind Therapy Clinic then we will assume that you have made an informed decision that you are taking the risk of such communication being intercepted. Please do not communicate an emergency by email or fax.

(Initial)_____

MESSAGES

It may be necessary at times for our office to leave you a message at the phone number(s) you provide us. By supplying us with specific phone numbers, you authorize us to leave messages for you at those numbers.

(Initial)_____

EMERGENCY ACCESS

We try to service our clients whenever possible; however we are not a 24-hour facility. In case of an emergency, if you are unable to talk with your provider, you are to call 911 or go to the nearest emergency room. If you call and leave a message and have not received a call back within a couple of hours and you feel it is an emergency, call 911 or go to the nearest emergency room.

(Initial)____

CONSENT FOR TREATMENT

I authorize and request my practitioner to carry out psychological exams, treatment and/or diagnostic procedures, which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. I understand and acknowledge that from time to time I may have a phone or video session. I authorize these sessions.

(Initial)____

ELECTRONIC RECORD KEEPING SYSTEM

Mind Therapy Clinic uses Electronic Medical Records (EMR) to securely maintain your health care information. Electronic Medical Record means an electronic record of health-related information that: includes my demographic and clinical health information, such as medical history and problem lists; and has the capacity: to provide clinical decision support; to support physician entry and billing invoices; to capture and query information relevant to healthcare quality; and to communicate with

me through patient portal about my care. By initialing here, I understand that my healthcare information is maintained in this way.

(Initial)____

USE OF INFORMATION RELATED TO MY TREATMENT

I give permission to Mind Therapy Clinic and its business associates to use my information if it relates to my treatment.

(initial)____

PATIENT AGREEMENT

Per the above, I have been notified by my physician and/or Mind Therapy Clinic of my responsibility for cancellation policy/fees. I authorize release of information to my Primary Care Physician, psychotherapist, psychiatrist, other healthcare providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I authorize the release of necessary information to a collection agency should that become necessary.

_____ _____

Patient Signature or Parent/Guardian signature if patient is a minor Date

PAYMENT RESPONSIBILITY

I understand that I am responsible for payment of all fees charged at the time of service unless otherwise agreed upon. I agree to pay for all services rendered. I understand that I may be given a receipt of services at my request that I may submit for reimbursement from my insurance carrier (if I have one) but that reimbursement is not guaranteed by Mind Therapy Clinic nor is my responsibility to pay for services dependent upon insurance reimbursement. I understand that Mind Therapy Clinic will bill me directly for any balances due from me that are not collected at the time of service, including, but not limited to, charges unpaid or missed appointments. I understand that if I fail to make payment on any balances due from me or make satisfactory payment arrangements with Mind Therapy Clinic for any balance due, they may turn my account over to a collection agency. I also understand that if any checks are returned by the bank for non-payment, that amount plus the $35 service charge will automatically be charged to my account.

I hereby consent to the release by Mind Therapy Clinic staff to any parties responsible for payment for my care any information deemed essential to ensure payment to Mind Therapy Clinic and continuation of necessary treatment services. Such information is limited to attendance, program schedule and fees.

(Initial)____

By signing below, I certify that I have read and understand this agreement and have full knowledge of its meaning and effect.

_____ _____

Responsible Party Name and Signature Date

MIND THERAPY CLINIC PAYMENT AGREEMENT

I acknowledge that Mind Therapy Clinic does not accept medical insurance. Therefore I choose to contract directly with Mind Therapy Clinic for psychiatric care.

I understand that I may request a receipt of services for my psychiatric care from Mind Therapy Clinic, which I may submit for reimbursement from my insurance carrier, but I further understand that my payment to Mind Therapy Clinic is not dependent upon my receiving reimbursement from my insurance carrier.

I understand that I must create an account with the medical office by submitting a credit card number prior to the scheduling of my next appointment. **I also understand that payment for all medical services is due at the time that they are rendered and will be charged to this credit card (Visa, Mastercard). I further understand that appointments that have not been cancelled in sufficient time (as per the Cancellation Policy as elsewhere agreed upon) will be charged to this credit card.**

Visa/MC Number:		
Expiration: MMYYYY	**CVV Code** (3 digits on back of card):	**Billing Zip Code:**
Name: (as it appears on the card)		
Cardholder Signature:		
Email Address:		
I hereby acknowledge that I have read, understand, and agree to this PATIENT PAYMENT AGREEMENT with Mind Therapy Clinic.		
Patient Signature:		**Date:**
Patient Name (print clearly)		
Guarantor Signature:		**Date:**
Guarantor Name: (print clearly)		

PLEASE NOTE: Per office policy, **payment is due at the time services are rendered. Patients must either provide a credit card to keep on file OR pay at the time of their visit.** If the patient is NOT the financially responsible party, a financially responsible person must provide a credit card on behalf of the patient for the office to keep on file. A statement can be sent to the address on file (or emailed if so requested) at the request of the patient or financially responsible party.

PATIENT REGISTRATION

Today's date:	Primary Care Clinician:

PATIENT INFORMATION

Patient's last name:	First name:	Middle:	Marital status: Single / Mar / Div / Sep / Wid

Is this the patient's legal name? ❑ Yes ❑ No	GUARDIAN's Email address:	DOB:	Age:	Gender: ❑ M ❑ F ❑ Other

Street address:	Mobile phone #:	Home phone #:

Address to send statement if different:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr._____ ❑ Insurance ❑ Facility Treatment

❑ Family ❑ Friend ❑ Close to home/work ❑ Website ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(FOR USE IN MEDICATION AND TREATMENT AUTHORIZATIONS)

Person responsible for bill:	Birth date: / /	Address (if different):	Phone no.:

Is this person a patient here? ❑ Yes ❑ No	Email Address:

Occupation:	Employer:	Employer address:	Employer phone no.:

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:

Subscriber's name:	Subscriber's SS:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Child ❑ Spouse ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Child ❑ Spouse ❑ Other

Revised March, 2019

PRIMARY CARE PHYSICIAN AND OTHER DOCTORS		
Primary MD Name:	Clinic Name:	
Street address:	City and State:	Zip Code:
Office Phone #:	Office Fax #:	
Other MD Name (if applicable):	Other MD Contact Information:	

I,_____, authorize Mind Therapy Clinic to communicate with my Primary Physician (if applicable) regarding my care ____(Initial)

THERAPIST AND PHARMACY				
Therapist Name (If Applicable):				
Street address:	City and State:	ZIP Code:	Office Phone #:	Office Fax #:

I,_____, authorize Mind Therapy Clinic to communicate with my Therapist (if applicable) regarding my care. _____(Initial)

Pharmacy (REQUIRED):				
Street address:			Office Phone #:	Office Fax #:
City:	State:	ZIP Code:		

CONTACTS - IN CASE OF EMERGENCY (BOTH PARENTS MUST BE LISTED FOR MINORS)			
Emergency Contact:	Relationship to patient:	Home phone #:	Work phone #:
For minors, names and contact information of parents/guardians:			

The above information is true to the best of my knowledge. In the event Mind Therapy Clinic submits claims on my behalf to my healthcare insurance provider, I authorize my insurance benefits to be paid directly to Mind Therapy Clinic. I understand that I am financially responsible for any balance. I also authorize Mind Therapy Clinic or insurance company to release any information required to process my claims.

Patient/Guardian Signature *Date*

PATIENT'S RIGHTS

You have the right to:

- Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
- Have written information about fees, method of payment, number of sessions, emergency policies, and cancellation policies before beginning therapy.
- Receive respectful treatment that will be helpful to you.
- A safe environment, free from sexual, physical and emotional abuse.
- Ask questions about your therapy.
- Refuse to answer any question or disclose any information you choose not to reveal.
- Request and receive information from the therapist about your progress.
- Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
- Know if there are supervisors, consultants, students or others with whom your therapist will discuss your case.
- Refuse a particular type of treatment, or end treatment without obligation or harassment.
- Refuse electronic recording (but you may request it if you wish).
- Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and the type of treatment.
- Report unethical and illegal behavior by a therapist.
- Receive a second opinion at any time about your therapy or therapist's methods.

If you wish to file a complaint about the clinic, please prepare a written complaint and place it in the suggestion box in the group therapy room. This information is confidential and will only be viewed by the clinic supervisor.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND SUBSTANCE USE RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ABOUT THIS NOTICE

Mind Therapy Clinic is required by law to maintain the privacy of your health information, to provide you with a notice of its legal duties and privacy practices, and to follow the information practices that are described in this notice. This notice explains how your health information may be used and disclosed and your rights related to your health information. You have a right to request and receive a paper copy of this notice.

Information regarding your health care, including payment of your health care, is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320s et seq., and 45 C.F.R. Parts 160 & 164. If you receive substance use treatment from Mind Therapy Clinic, your information related to these services, including whether or not you receive these services, is also protected under the Confidentiality Law, 42 C.F.R. Part 2 ("Part 2"). Mind Therapy Clinic may not use or disclose your health information except as described in this notice and as permitted under the law.

This notice applies to health information about you that is obtained by or on behalf of Mind Therapy Clinic. Health information is information that relates to your past, present, or future physical or mental health or condition, the provision of health care products and services to you or payment for such services. We will notify you of any breach involving your health information in accordance with applicable law.

HOW WE MAY DISCLOSE YOUR HEALTH INFORMATION

As permitted by law, your treatment provider is permitted to and may choose to use or disclose protected health information (information regarding your treatment at the Mind Therapy Clinic or other relevant information that may identify you) ("PHI") without your authorization for the purposes described in this notice.

When it is important to do so, we will only use or disclose the minimum necessary PHI to the extent a recipient needs to know the information. By law, mental health professionals shall safeguard the confidential information obtained in the course of practice, research, teaching or any other professional duties. Except for the purposes set forth below, the mental health professional may only disclose your PHI to others with your written consent.

Please note that the ethical standards of mental health professionals are, in many cases, more stringent than federal and state regulations and restrict us from unnecessarily disseminating information about you. We will only do so as necessary, and will use caution with any information pertaining to you or your health status.

EXAMPLES OF HOW WE MAY USE AND DISCLOSE PHI (EXCEPT ANY INFORMATION RELATED TO SUBSTANCE USE TREATMENT YOU RECEIVE AT MIND THERAPY CLINIC)

The following section describes how Mind Therapy Clinic may use and disclose your PHI, other than information relating to any substance use treatment you may receive at Mind Therapy Clinic (for how such information may be used and disclosed, please see "Examples of How We May Use and Disclose Your Health Information that Relates to Substance Use Treatment Received at Mind Therapy Clinic", below).

Examples of Disclosure for Treatment, Payment, and Health Care Operations

Treatment. We may use PHI about you to provide you with medical treatment or services. We may disclose PHI about you to doctors, nurses, technicians, office staff, or other personnel who are involved
in your care or health care decisions. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Payment. We may use and disclose PHI about you so that the treatment and services we provide to you may be billed to and payment may be collected from you, an insurance company or a third party.

Health care operations. We may use and disclose PHI about you in order to run Mind Therapy Clinic and make sure that you and our other clients receive quality care. For example, we may use your information to conduct cost-management and patient-care planning activities for Mind Therapy Clinic.

Examples of Other Uses and Disclosures

We also may use and disclose your PHI without your prior authorization for the following purposes: To Business Associates of ours, with whom we contract for services. Examples of Business Associates include consultants, accountants, lawyers, and third-party billing companies. We require these Business Associates to agree to protect the confidentiality of your PHI.

To health oversight agencies or authorities for health oversight activities, such as auditing and licensing. For public health purposes, including reports to public health agencies or legal authorities charged with preventing or controlling disease, injury, or disability and reports to employers for work-related illness or injuries for workplace safety purposes

To law enforcement authorities for law enforcement purposes as required or permitted by law for example, in response to a subpoena or court order, in response to a request from law enforcement, and to report limited information in certain circumstances.

For judicial and administrative proceedings, including if you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to first tell you about the request or to obtain an order protecting the information requested.

As Required by Law. We will disclose your PHI when required to do so by federal, state or local law. To make reports on abuse, neglect, or domestic violence to a government authority if we reasonably believe you are a victim of abuse or neglect. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else.

To avert a serious threat to public health or safety, or to prevent serious harm to an individual. To Coroners and medical examiners and funeral directors, as necessary, to carry out their duties. To organizations for purposes of disaster relief efforts.

For research projects that are subject to a special approval process. We may use your health information to conduct research and we may disclose your PHI to researchers as authorized by law. For example, we may use or disclose your PHI as part of a research study when the research

has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

For specialized government functions; for example, as required by military authorities or to federal officials for intelligence, counterintelligence, protection of the President, and other national security activities authorized by law.

To correctional Institutions if you are or become an inmate of a correctional institution, for your health and the health and safety of other individuals.

For workers compensation purposes as necessary to comply with worker's compensation or other similar programs established by law.

Incidental Disclosures. While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during, or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

In other instances, we may use or disclose PHI without written authorization but provide you with an opportunity to agree or object to the use or disclosure. This will occur when a use or disclosure to a family member, relative or close personal friend, or any other individual you identify, is important to provide these individuals with information regarding your health care, payment, location, general condition or death, or to assist in disaster relief efforts. In emergency circumstances, we may not be able to obtain your agreement or objection; in these cases we will use our professional judgment to act in your best interests.

EXAMPLES OF HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION THAT RELATES TO SUBSTANCE USE TREATMENT RECEIVED AT MIND THERAPY CLINIC

The following section describes how Mind Therapy Clinic may use and disclose your health information that relates to substance use treatment received at our clinic. Under federal regulations referred to as Part 2, more stringent confidentiality and privacy protections apply to your health information that identifies you as a substance use treatment patient (“Part 2 Information”). We may not disclose to a person outside of Mind Therapy Clinic that you received substance use treatment at our clinic, nor may Mind Therapy Clinic disclose any Part 2 Information, except as permitted by federal law. Mind Therapy Clinic must obtain your written consent before it may disclose Part 2 Information for payment purposes. Generally, you must also sign a written consent before Mind Therapy Clinic can share Part 2 Information for treatment or for health care operations.

Examples of Disclosures Of Part 2 Information
Under federal law, we may use and disclose Part 2 Information without your prior consent for the following purposes: Pursuant to an agreement with a qualified service organization/ business associate, with whom we contract for services; For research, audit, or evaluations; To report a crime committed on Mind Therapy Clinic’s premises or against Mind Therapy Clinic’s personnel; To medical personnel in a medical emergency; To appropriate authorities to report suspected child abuse or neglect; and As allowed by court order.

OTHER USES AND DISCLOSURES

Your written authorization is required to disclose psychotherapy notes, except in cases in which we must use such information to defend ourselves in legal action/proceedings involving you.

Before Mind Therapy Clinic may use or disclose any information about your health in a manner not described in this Notice, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by your orally or in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information, except to the extent that we have already taken action in reliance on the authorization

YOUR RIGHTS

You have individual rights over the use and disclosure of your PHI, including the rights listed below. You may exercise any of these rights by submitting your request in writing. Please contact the Office

Manager to obtain the applicable request form. We will evaluate each request and communicate to you whether or not we can honor the request. We may also charge a reasonable fee for costs associated with your request to the extent permitted by law. We will notify in advance of the cost, and you may withdraw your request before you incur any cost.

Restrict use
You may request, in writing, restrictions on certain uses and disclosures of your information. We will consider but are not legally required to accept most requests. After review of your request, we will notify you of our determination in writing. We must accept your request only if the restricted disclosure is to a health plan for the purpose of carrying out payment or health care operations, disclosure of such information is not required by law, and the restricted information pertains to an item or service for which you paid in full out-of-pocket.

Upon request, you may receive confidential communications by alternative means or at alternative locations. This includes an alternative mailing address or telephone number.
Inspect and copy
With a few exceptions, you have the right to access and obtain a copy of the health information that we maintain about you. If we maintain an electronic health record containing your health information, you have the right to obtain the health information in an electronic format. You may ask us to send a copy of your health information to other individuals or entities that you designate. We may deny your request to inspect and copy in certain circumstances. If you are denied access to your health information, you may request that the denial be reviewed in some cases.

Request corrections
You have the right to request in writing that we correct information in your record that you believe is incorrect or add information that you believe is missing.

Know about disclosures
You have the right to an accounting of instances where we have disclosed your health information for certain purposes other than for treatment, payment, health care operations, or other exceptions. Your request must be made in writing and may be for disclosures made up to 6 years before the date of your request.

File complaints
If you are concerned that we have violated your privacy or disagree with a decision we made about access to your record, you may file a complaint about the clinic and submit it to our HIPAA Officer You also may file a written complaint to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized nor retaliated against if you file a complaint.

CHANGES TO THIS NOTICE

This notice is effective as of March 1, 2019. We may change the terms of our notice at any time. The new notice will be effective for the health information that we maintain. The revised notice will be posted at our places of service. You may request a copy of the current notice at any time by contacting our HIPAA Officer at 415-945-9870.

Acknowledgment

I/We,_____, acknowledge receiving and reading a copy of the above information, and have had the opportunity to askwhatever questions necessary for clarification.

Client_____ Date_____

If no signature is obtained, document efforts to obtain signature and reasons why the document was not signed:

HOURS OF OPERATION

Mind Therapy Clinic's clinical/business hours are **Monday-Friday 9:00 am to 6:00 pm**
For situations arising after hours and on weekends:

Marin	San Francisco
Call 911 for emergencies.	
Call Marin Crisis Center, 415 473-6666 ext 24, for psychiatric emergency services including urgent consultation.	Call SF Crisis Hotline (415) 781-0500 or 800 /273-8255
Visit the Marin Psychiatric Emergency Room on the Marin General Hospital campus at 250 Bon Air Rd in Greenbrae.	Crisis Text Line 24/7 Confidential Support: text MYLIFE to 741741
Leave a message for the primary therapist, physician or family therapist in the event you have sought help from any of the above.	Visit the SF Psychiatric Emergency Services on the SF General Hospital campus at 1001 Potrero Ave., San Francisco 94110. Phone number: 415-206-8125
For non-emergencies: Leave a message for the primary therapist, physician or family therapist who will generally respond within one business day.	Leave a message for the primary therapist, physician or family therapist in the event you have sought help from any of the above
	For non-emergencies: Leave a message for the primary therapist, physician or family therapist who will generally respond within one business day.

Medication refills are provided during regular business hours. Please request medication refills directly from your pharmacy, allowing at least **five (5)** business days before running out. Have your pharmacy send refill requests electronically or by fax to: **415 945-9325.** For refills or prescription problems contact **415 945-9870**. *Note - most pharmacies will provide a one or **two (2)** day emergency supply of most medications.

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION FOR PRIOR AUTHORIZATION OF MEDICATION

I authorize Mark Schiller, M.D. and Mind Therapy Clinic to submit my patient information to CoverMyMeds for the purpose of assisting in managing the prior authorization or other coverage determination process for prescription drugs. This information may include but is not limited to my name, date of birth, address and contact information, my medical condition, my treatment history, including prescription medications, my health insurance information, and/or financial information. This information is considered Protected Health Information ("PHI"), and is subject to local, state and federal regulations, and the HIPAA Privacy Rule, located at 45 CFR Part 160 and Subparts A and E of Part 164.

Once my PHI is submitted to CoverMyMeds, I understand that it will be used to submit coverage determinations to my health plan, and may be shared with related physician or pharmacy staff involved in my care. I understand that my information will be used only to the extent necessary to submit coverage determinations, and will not be published to those not involved in my care. However, I acknowledge that once my PHI is disclosed to third parties, it may no longer be subject to protection under the HIPAA Privacy Rule. I can review the full privacy policy at: http://www.covermymeds.com/main/privacy_policy or by writing to: Privacy Office, CoverMyMeds LL, 2 Miranova Pl., Floor 12, Columbus, Ohio 43215 or emailing to privacy@covermymeds.com

This authorization will be effective until I notify my provider that I do not want my information to be disclosed to CoverMyMeds. I understand that I can revoke this authorization at any time, that I am not required to sign this form, and that my healthcare provider cannot condition treatment or eligibility for benefits on my execution of this authorization. I understand that I have a right to receive a copy of this form.

_____ _____

Name of the Guardian (Please print) Relationship to Patient & Signing Rights

_____ _____

Signature Date

This authorization form does not form a relationship between the patient and CoverMyMeds or its customers. This form may be modified for use by healthcare providers who wish to supplement their existing consent program to ask for specific patient approval to use the CoverMyMeds service in the course of patient care. Providers should ensure that their consent program meets all applicable local, state, and federal regulations.

CHILD/ADOLESCENT INTAKE EVALUATION

(Attach additional sheets if needed)

Name:	Date of Birth:	Age:	Date:
Others Present:			
Person completing this intake questionnaire:		Marital Status: *Married/Divorced/ Separated/Single/In Relationship*	
Please name all persons who have legal medical decision-making authority for this patient?*			
*If applicable, please bring a copy of the court decree stating who has medical decision-making authority			
Staff Use Only: Court decree brought in on: _____ Accompanying adult instructed and agrees to obtain a copy of the court decree: _____			
Current living situation (relationship of person(s) with whom patient resides)?			
Allergies to medication: ☐ Yes ☐ No		If YES, please describe each allergy and adverse reactions.	
Current medications: (IMPORTANT: Please list any prescription and non-prescription medications, vitamins, supplements or herbs; include name, dose, and how often taken):			

REASON FOR THIS APPOINTMENT

What are the reasons you scheduled an appointment with us?		
How long has your child had these symptoms?		
Are these symptoms related to a life situation?	☐ Yes	☐ No
If YES, please explain:		
Do these symptoms seem to come and go regularly, as in a cycle?	☐ Yes	☐ No
If YES, please describe:		
Has your child experienced Post-Traumatic Stress Disorder (PTSD) or any traumas including physical, emotional or sexual abuse?	☐ Yes	☐ No
If YES, please describe?		

Please check the boxes below for all that apply to your child:		
☐ Runny or stuffy nose	☐ Frequent coughing or wheezing	☐ Dark circles or bags under the eyes
☐ Aggression such as biting, hitting, spitting, pinching, punching and kicking	☐ One or both ears red and/or burning	☐ Refusal to be touched
☐ Dry flaky lips		
Are there other <u>medical symptoms</u> we should know about (e.g. forgetfulness, weight changes, dry, coarse skin/hair, change in bowel habits etc)?		

ADD/ADHD Symptom Information		
Has your child previously been evaluated for ADD/ADHD?	☐ Yes	☐ No
If YES, please tell us who performed the evaluation, tests performed, and results.		

What are the primary symptoms related to your child's ADD/ADHD:		
☐ Attention	☐ Impulsivity	☐ Focus
☐ Distractibility	☐ Restless/always active	☐ Oppositional
Please describe these symptoms in more detail and how they are affecting your child's life in the following Areas:		
Home:		
School or Work:		
Relationships:		
How long have these symptoms have been a problem for your child?		
Are these symptoms:	☐ Always present	☐ Intermittent
Please describe your selection above:		

☐ Has difficulty remaining seated	☐ Has difficulty awaiting turns
☐ Blurts out answers to questions before they have been completed	☐ Has difficulty playing quietly
☐ Talks excessively	☐ Interrupts or intrudes on others
☐ Squirms in seat or fidgets	☐ Inappropriately runs or climbs
☐ Appear driven or "on the go"	

ADD/ADHD/Learning Disorder Background Information

Developmental Milestones: (Check any of the following that may apply. As an infant, the patient usually:

☐ Was restless, squirmy, into everything	☐ Was fussy and unhappy
☐ Had difficulty in how he/she handled change in routine	☐ Did not enjoy cuddling
☐ Protested when first introduced to new foods, places, or people	☐ Was not calmed by holding or stroking
☐ Was intense and/or loud	☐ Had colic
☐ Was unpredictable in feeding and sleeping	☐ Had sleep problems
☐ Was sensitive to noise, texture, clothing	☐ Was hard to arouse while asleep
☐ Had bedwetting or problems with soiling (until age: _____)	

Behavior/Characteristics: (Check any of the following symptoms that apply to the patient (off medication) either now or in the past)

☐ Fails to pay attention to details or is careless	☐ Has difficulty organizing tasks and activities
☐ Is forgetful in daily activities	☐ Doesn't seem to listen to what is being said
☐ Avoids, dislikes or is reluctant to engage in tasks requiring sustained mental effort	☐ Neither follows through on instructions nor completes chores, schoolwork or jobs (*not* because of oppositional behavior or failure to understand)
☐ Is easily distracted by external stimuli	☐ Loses things
☐ Has trouble keeping attention on tasks or play	☐ Shifts from one uncompleted activity to another

Does your child experience alterations in mood?	☐ Yes	☐ No
Does your child misbehave to a greater degree than other children?	☐ Yes	☐ No
Does your child have poor school performance?	☐ Yes	☐ No
Does your child sleepwalk?	☐ Yes	☐ No
Does your child have night terrors?	☐ Yes	☐ No
Please describe any of the items above.		

Sleep Habits		
Does your child have trouble falling asleep?	☐ Yes	☐ No
If YES, how long does it take for your child to fall asleep? Please describe why your child has trouble if you know.		
How is the quality of your child's sleep (e.g., light, deep, etc.)?		
Does your child wake up in the middle of the night?	☐ Yes	☐ No
If YES, how often?		
Is your child able to fall back to sleep?	☐ Yes	☐ No
Does your child snore?	☐ Yes	☐ No
Does your child stop breathing or gasp for breath when asleep?	☐ Yes	☐ No
Does your child have unexplained bedwetting?	☐ Yes	☐ No

Head Injuries:			
Has your child ever had any head injury, sports injury to the head, falls, concussions or car accidents?	☐ Yes	☐ No (Skip to the next section)	
If YES, please describe where on the head the injury occurred and at what age:			
Did your child experience amnesia or lose consciousness after the injury?	☐ Yes	☐ No	☐ Don't Know
Has there been any change in mood or memory since the head trauma occurred?	☐ Yes	☐ No	
If YES, please describe the change in mood or memory.			
Was your child hospitalized for the head injury?	☐ Yes	☐ No	
If YES, please provide details of the hospitalization.			
Was any type of scan performed (CAT, MRI, EEG, etc.)?	☐ Yes	☐ No	☐ Don't Know
If YES, what did it show?			

CHILDHOOD/CULTURAL HISTORY

Please describe your child's family life, include whether the family is intact, parents are divorced and if so, how old your child was, and custody arrangements, etc.)

Please tell us who lives with the child including the names, relationship to the child, and age of each person

SCHOOL PERFORMANCE

(If patient is out of school, complete as to what did occur)

Current Grade and School:	Grade:	School:

How does the patient do in school? (In grade school and high school) - what do teachers say; does your child live up to his/her academic potential? How about absences, tardiness, and alertness in class, etc.)

Does the student have an IEP (Individualized Education Program) or 504? If YES, please bring a copy of the evaluation.	☐ Yes	☐ No
Do you understand why the student has an IEP or 504? If YES, please describe your understanding of it.	☐ Yes	☐ No

If YES, please describe your understanding of it.

Do you feel that the school has followed through with the suggested accommodations described in the IEP or 504?

LEGAL HISTORY		
Has your child ever been involved with the legal system?	☐ Yes	☐ No
If YES, please explain:		
Is your child presently on diversion or probation?	☐ Yes	☐ No
If YES, what are the requirements of the diversion or probation?		

SUBSTANCE USE		
Do you have any concerns about substance or alcohol abuse with your child?	☐ Yes	☐ No
If YES, please explain:		