Foundations for Change, PLC

Phone: 602-399-5792 Fax: 602-297-6738

Consent for Treatment

I/we are providing consent for _____
Patient's name
to receive behavioral health and psychiatric treatment including medication management, therapy, and diagnostic procedures by the clinicians, providers, employees and/or independent contractors of Foundations for Change, PLC.

I/we understand the following:

- I/we have been fully informed about the nature of the treatment, the risks and benefits, and the available treatment options
- I/we have had the opportunity to have all questions answered to my/our satisfaction.
- This consent is given voluntarily.
- I am legally competent and have the authority to provide consent for treatment.
- I have the right to withdraw my consent for this treatment at any time.
- Withdrawing consent for this treatment will not prejudice my continued treatment relationship.

1. Appointments: The Office Manager schedules all appointments. We do not overbook or double book; the time you schedule is yours. Our first meeting will last approximately 1 hour. We will discuss the issue that have led you to seek assistance, your past history, current life status and treatment goals. Ongoing sessions for medication management will last approximately 15-20 minutes. If you do not intend to keep your appointment, wish to cancel or reschedule your appointment, and do not contact this office at least 24 hours prior to the appointment time, you will be charged half of the full appointment cost.

2. Treatment is a team effort. To provide the best possible care, the safest level of care, and to ensure clear communication, you are asked and expected to attend your medication and therapy appointments. Emergencies and life circumstances will be discussed on a case-by-case basis. Please note the following and ask any questions you may have prior to signing this consent:

   a) If you cancel an appointment and do not reschedule, we will attempt to contact you and reschedule your appointment. If you fail to respond to our efforts to contact you, or after scheduling a second appointment you cancel or fail to keep this second appointment, you will be notified in writing of our intent to close your case. Referrals will be provided to you in writing in the event you may wish to contact another provider for continuation of services.

   b) If you are a no-show for an appointment you will be notified in writing of our intent to close your case. If you call to reschedule we will schedule one further appointment to engage with you once again in treatment. If you have a second no-show your case will be closed and referrals to other providers will be given to you in writing that you may wish to contact for continuation of services.

   c) If you do not feel that Foundations for Change, its providers, or therapists are a good fit for you as a treatment team we will make every effort to help you find services that better fit your needs.

   d) Providing refills for any client without face-to-face consultation and assessment is not a standard practice of Foundations for Change. **Refills for medication will only be given for one missed appointment if notification is provided to this clinic prior to missing your appointment.** We will not refill prescriptions given to you by another provider.

3. Jeff Edelman, owner of Foundations for Change, is currently serving his country in the US Army Reserves. It is possible that he may be deployed in the future. He will receive 30 days' notice of deployment and upon receipt of that notice will notify his personal clients regarding his imminent deployment. Maximum effort will be made to provide support and referrals to providers and services either within Foundations for Change or with another provider.

   a. After Hours, Weekends, and Holidays: When the office is closed you can leave a brief message on the answering machine. We will call back the next business day.

b. Emergencies: This office does not provide any emergency services. If you have a life threatening emergency, call **911** or go promptly to and Emergency Room.

4. Risks Associated with treatment: Please be aware that there can be risks associated with psychiatric medications. It is my goal to protect your safety and well-being at all times. However, in many situations progress cannot be made without assuming some risk of adverse effects. All medication can have side effects, some of which may be quite serious. Prior to starting any new medications, it is my responsibility to discuss with you the most common and most serious potential side effects, and to help you weigh these risks against the potential benefits. I will answer any question you may have about the medications I recommend, at any time. Please be aware, however, that I cannot practically inform you of every possible side effect of each medication.

5. Record Release: It takes our office 4 to 5 business days to process medical records request. Medical records will be released to any physician upon your written request and authorization as a courtesy. The fee for "non-treatment" medical records is $1.00 per page and payment is required upon release of the medical release.

6. Forms Completion: Completion of forms for insurance purposes, disability, or FMLA leave, will be billed to the patient, or representative that requests completion of the forms, at a fee of $20.00 per page. It takes our office 4 to 5 business days to complete these forms.

7. Referrals/Authorizations: Referrals/authorizations from your Primary Care Physician or Insurance Carrier approving visits to our office can take several days to retrieve. **You are required to contact your Primary Care Physician at least 1 week in advance to notify them of your appointment.** Failure to do so may result in your referral/authorization being denied by your Primary Care Physician and/or insurance company; therefore making you responsible for any and all charges incurred during your visit.

Insurance and Payment Policies

- **Proof of Insurance**: We ask that you present your insurance card to us at every visit. If you fail to provide us with the correct insurance information at each visit, you may be responsible for payment for all services provided.
  Your health insurance contract is between you and your insurance company. Knowing your insurance benefits is your responsibility. Any questions or complaints regarding your coverage should be directed to your insurance company.
  We are contracted with most insurance plans. If you are not insured by a plan we are contracted with, payment in full is expected at the time of service. If you are insured by a plan we are contracted with but do not have an up-to-date insurance card, payment in full is required until we can verify your coverage.
  If you are uninsured please contact our business office at 602-399-5792 to obtain quotes for impending services.
- **Co-Payments/Deductibles**: Your insurance company requires us to collect co-payments and/or deductibles at the time of service. Waiver of co-payments and/or deductibles may constitute fraud under the state and federal law.
- **Non-covered Services**: Please be aware that one of all of the services you receive may be non-covered or not considered medically necessary by your insurer. You must pay for these services in full.
- **Claims Submission**: We will submit your claims and assist you in any way we reasonably can to help you get your claim(s) paid. Your insurance company may need you to supply certain information directly. It is your responsibility to promptly comply with their request.
- **Account balances**: Are to be paid in full at the time of service.

_____ Date _____
Patient signature*

_____ Date _____
Parent/legal guardian signature

_____ Date _____
Treatment provider/witness

*** If patient is a minor, signature may be required, depending on state law.**

Foundations for Change, PLC

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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 IT CAREFULLY

Our pledge regarding Medical information:

We understand that medical information about you and your health is personal and private. We are committed to protecting medical information about you in accordance with all federal and state laws. When you receive services at the Office we create a record and need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to the Office's records that are generated by your visit to this office, whether these records are made by this office or your personal doctor.

Who will follow these privacy practices:

This notice describes the practices of the office and that of any health care professional that is authorized to practice at this office and to enter information into your medical record at this office. All of our employees, staff and other personnel at this office have agreed to follow the terms of this notice. In addition, these individuals may share medical information with each other for treatment, payment, or the offices operations purposes described in this notice.

How we may use and disclose medical information about you:

The following categories describe different ways that we may use and disclose medical information. For each category of uses of disclosures we will explain what we mean and may give examples. While not every use or disclosure in a category is listed, all of the ways we are permitted to use and disclose information will fall within one of the categories. **However, we will make every effort to protect you and your confidential health information and will make every effort to speak with you prior to any situation that may occur, requiring disclosure of your information within the boundaries of Federal and State law.**

- **For treatment**: we may use medical information about you to provide you with medical treatment/services. We may disclose medical information about you to doctors, nurses, or therapist or other office personal who are involved in you care at this office. For example this office may need to contact your other providers to provide you with the best care.
- **For payment:** We may use and disclose medical information about you so that the treatment/services you receive may be billed to and payment collected from you, your insurance company or a third party. For example we may need to give health plan information about your services you received at this office so your health plan will pay us.
- **For health care operations:** We may use and disclose medical information about you for office operations or for operations related to organized health care arrangements with providers who with treat you in this office. For example: we may use medical information to review our services and to evaluate the performance of our staff in caring for you.
- **Procedure alternatives or health related benefits or services**: We may use and disclose medical information to tell you or your physician about or recommend possible treatment options or alternatives that may be of interest to you or more appropriate. We may also use and disclose medical information to tell you about health-related benefits or services that may be of interest.
- **Business associates:** we may disclose medical information to those that we contact with a business associates so they may do their jobs on behalf of this office. Examples include management services, transcription services, translator services, and EMR companies. We require that all business associates implement appropriate safeguards to protect your medical information.
- **As required by law:** We will disclose medical information about you when required to do so by federal, state, or local law.
- **To avert a serious threat to health or safety**: we may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure however would only be to someone who is likely to help prevent the threat.
- **Special Situations**:
- **Military Personnel:** If you are a member of the armed forces, we may release medical information about you **as required by military command authorities.** We may also release medical information about foreign military personnel to the appropriate military authority.
- **Public health activities:** we may disclose medical information about you **as authorized or required by law** for public health activities. These activities generally include the following:
  - To prevent or control disease, injury or disability
  - To report births and death
  - To report child abuse or neglect
  - To report reaction to medications or problem with products
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

NOTICE OF PRIVACY PRACTICES

- To notify the appropriate government authority if we believe you have been the victim of abuse neglect or domestic violence. **We will only make this disclosure if you agree or when required or authorized by law.**

- **Health oversight activities:** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Law Enforcement:** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process
  - Where required by federal, state, or local law.
- **National security and intelligence activities:** We may release medical information about you to authorized federal officials for intelligence, counter intelligence, and other national security activities authorized by law.
- **Security Clearances:** we may use medical information about you to make decisions regarding your medical suitability for a security clearance or service abroad. We may also release your medical suitability determination to the official's in the US department of state who needs access to that information for these purposes.
- **Department of justice:** we may disclose limited information to the Arizona department of justice for movement and identification purpose about certain criminal patients or regarding persons who may not purchases posses or control a firearm or deadly weapons.
- **Multidisciplinary personnel teams:** We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents or elder abuse and neglect.

Your rights regarding medical information about you: You have the following rights regarding medical information we maintain about you:

- **Right to inspect and copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes, information we put together to prepare for a legal action, and certain information covered by laws relating to laboratories. To inspect and copy medical information that may be used to make decisions about you, you must submit you request in writing to this office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may be able to request that the denial be reviewed. Another licensed health care professional chosen by this office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. In certain limited situations, we will have to deny you access but will not be able to give you a review.
- **Right to amend:** If you feel that medical information we have about you is incorrect or incomplete, you may to amend the information. You have the right to request an amendment for as long as the information is kept by or for this office. To request an amendment, your request must be made in writing and submitted to this office. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writhing or does not include a reason to support the request. In addition, we may deny your request if you ask to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
  - Is not part of the medical information kept by this office?
  - Is not part of the information which you would be permitted to inspect and copy
  - Is accurate and complete

  If we deny your request for an amendment, we will notify you of the reason for the denial. If you disagree with our denial, you may submit a statement of disagreement or ask that your request become part of your record, In response we may prepare a rebuttal statement. These will be made a part of your record.

- **Right to an accounting of disclosure:** You have the right to request an "accounting of disclosure". This is a list of most of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to this office. Your request must state a time period. Your request should indicate in what form you want the list ie ;(on paper electronically). This first list your request within a 12- month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw

or modify your request at that time before any costs are incurred. In addition, we will notify you as required by law if your health information is unlawfully accessed or disclosed.

- **Rights to request restrictions:** You have the right to request a restriction of limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about your to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a type of therapy you had. We are not required to agree to all restrictions request if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we provide you. We cannot however, restrict your request to not disclose health information to a health plan for payment or health care operations. This pertains solely to a health care item or service for which the provider involved has been paid out of pocket in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
  To request restrictions, you must make your request in writing to this office. In your request, you must tell us A) what information you want limit; B) whether you want to limit our use, disclosure or both; and C) to whom you want the limits to apply, for example, disclosure to your spouse.
- **Right to request confidential communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to this office. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify who or where you wish to be contacted.
- **Right to a paper copy of this notice:** You have the right to paper copy of this notice. You may ask us to give you a copy of this notice at any time.
- **Our responsibilities regarding your medical information:** We are required by law to A) keep medical information that identifies you private; B) give you this notice of our legal duties and privacy practices with respect to medical information about you; and C) follow the terms of the notice that is currently in effect.
- **Change to this notice:** we reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in this office. The notice will contain on the first page, top left-hand corner, the effective date.
- **Complaints:** If you believe your privacy rights have been violated, you may file a complaint with this office or the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.**
- **Other uses of medical information:** Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provided us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Foundations for Change, PLC

RECEIPT OF PRIVACY PRACTICE NOTICE

I acknowledge that I have received from Foundations for Change,

A Health Insurance Portability and Accountability Act Notice of Privacy

Practices regarding use and disclosure of my health information. I

Understand that Foundations for Change has the right to change this notice at any time. I may obtain a current copy by contacting the office.

I am aware that Foundations for Change will follow the strictest policy in guarding my confidentiality.

My signature below constitutes my acknowledgement that I have been provided with a copy of and understand the notice of privacy practices.

_____	_____	_____
Patient Name	Patient or Parent/Guardian Signature	Date/Time
	_____	_____
	Staff Signature	Date/ Time

Foundations for Change
Child/Family & Adult
Psychiatric Services

Patient Payment Responsibility/Agreement

Client (guardian if Minor): _____ Phone: _____

Address: _____ Email: _____

Clinic: _____ Doctor: _____ Insurance: _____

I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from the staff of Foundation's for Change, PLC. I therefore authorize the medical staff and personnel to release mine or my minor child's medical information to the insurance company listed above (if accepted by Foundations for Change PLC) for the purpose of determining and receiving benefits for medical bills.

(_____) Initials

I understand and acknowledge that Foundations for Change, PLC currently only accepts insurance from the following insurers:

Tri-Care -Blue Cross Blue Shield -Aetna -Cigna -HealthNet-Humana- MultiPlan

(_____) Initials

I understand that, if my insurance is not accepted by Foundations for Change PLC, or if I do not have insurance, I will be billed at the cash rate and I will be responsible for the total amount due at time of service

(_____) Initials

If my insurance is listed above and accepted by Foundations for Change PLC, I understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required.

(_____) Initials

I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for nonpayment. (_____) Initials

In the event my account is assigned to a collection agency due to non-payment, I agree to pay any reasonable collection fees and legal fees up to 33.33% (_____) Initials

Patient / Guardian Signature _____ Date _____

Foundations for Change
Child/Family & Adult
Psychiatric Services

PATIENT RIGHTS

- Patient may withdraw consent at any time
- Patient must provide consent to release information except where required by law
- Patient has right not to be discriminated against based on age, race, national origin, religion, gender, sexual orientation, disability, marital status, or diagnosis.
- Patient has right to receive privacy in treatment and care for personal needs.
- Patient has right to receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities
- Patient has right to review upon written request patients own medical record
- Patient has right to receive a referral to another health care institution if the OPTC is not auothorized or not able to provide physical or behavioral health services needed by patient
- Patient has right to participate in decisions concerning treatment
- Patient has right to participate or refuse to participate in research or experimental treatment
- Patient has right to receive assistance from a family member or others in understanding, protecting, or exercising the patient rights.
- Patient has right to be treated with dignity, respect, and consideration
- Patient is not to be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault, retaliation for submitting complaints, and misappropriation of personal and private property.

By signature below you attest that you understand and have been provided with a copy of these patient rights.

Patient / Guardian Signature_____ Date _____