Adler Psychiatry
4121 Montgomery Blvd NE,
Albuquerque, NM 87109
(505) 807-0055 Office
(505) 299-2649 Fax
www.AdlerPsychiatryNM.com

Welcome to Adler Psychiatry

Thank you for choosing Adler Psychiatry for your mental health needs. We are a small practice with all communication being completed electronically/online via Email/Text/Voicemail. Therefore it is critical that your email and phone number are correct. We ask that you complete this form ASAP to facilitate the onboarding/intake process for your appointment. If this information is not obtained in a reasonable timeframe, your appointment may need to be rescheduled. Please understand that it takes time to validate insurance, check your co-pay, and get your file ready for your visit. We recommend you take the time to fill this out as soon as you get it.

Thank you, and welcome to Adler Psychiatry.

Please enter the patient's information.

First Name: ______ Middle Initials: ______ Last Name: ______

Preferred Name ______

Date of Birth: ______

Gender Assigned at Birth:
- Male
- Female

Gender Identity ______ Preferred Pronouns ______

Marital Status:
- Single
- Married
- Domestic Partner
- Separated
- Divorced
- Widowed

Street Address: ______ Apt./Unit #: ______ City: ______ State: ______ Zip Code: ______

Mobile Phone: ______ Home Phone: ______ Work Phone: ______

Email: ______ Preferred contact method: ______

Emergency Contact ______

Emergency Contact Relationship ______ Emergency Contact Phone Number ______

Pharmacy Name ______ Pharmacy Phone Number ______

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Practice Agreement

This document contains important information about my professional services and business policies. Following this document, I have a summary of information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protection and patient rights regarding the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is important that you understand them. I will require you to sign a form indicating you have read these documents and agree to my policies.

Initial Appointment

The intake process includes an assessment of your present concerns, review of your history, identification of treatment goals, and formulation of a treatment plan. Often 2-3 sessions are required before the evaluation is complete. No medications will be prescribed at the initial appointment.

Follow-Up Appointments

Once the evaluation process is complete, I will offer my clinical impression and formulate an initial treatment plan. At this time we will discuss whether medications would be beneficial, and if so, what specific agents I recommend for your treatment. I may also recommend and assist you with a referral to therapy.

During this time, we will discuss your goals and establish next steps for treatment. Generally, the frequency of follow-up appointments reduces as a client becomes more stable. Follow-up appointments are also used to re-evaluate goals, determine efficacy of treatment, and discuss any side-effects.

Office Practice

It is important that we both commit to being on time for appointments. If you are more than 10 minutes late to an appt you will be rescheduled and incur a fee for a missed appointment. Adler Psychiatry willbill your insurance company for the services I provide. There may be deductibles, copays and/or coinsurance that are due at the time of service. It is your responsibility to pay for any costs not covered by your insurance. I recommend contacting your insurance carrier and asking if you have outpatient mental health care coverage, determine your deductible and/or copays, and if I am a covered provider under your plan. If you are running late, please call the Office at 505-807-0055.

Cancellation Policy

Medication management is most productive when regular appointments are kept. From time to time it may be necessary to cancel or change an appointment. If that is necessary, I require 24-hour advance notice to cancel or change an appointment. If that is not given, **you will be responsible for the full fee** for that appointment as insurance cannot be billed for missed or late cancelled appointments. We realize

that there are circumstances that exist where giving notice may not be feasible. I understand that it may not be possible to give 24 hours' notice due to illness, injury or emergencies. On a case by case basis the cancellation fee may be waived. **The fee for a missed or late cancellation of an appointment is $200 for a follow-up appointment and $350 for an intake appointment.**

Medication Refill Policy

It is my policy to provide refills for prescribed medications only during scheduled follow-up appointments, this includes controlled substances. If you run out of a medication before it is due I will not refill it. Do not increase any of your medications prescribed by me without my consultation.

Please keep track of when your refills are needed to ensure you have enough medication to last until your next scheduled appointment (Please allow at least 3 days notice for refill requests). If you miss your scheduled follow up appointment your medications may not get refilled.

I recommend getting all your medications, from all prescribers, filled at the same pharmacy. This facilitates safety regarding drug-drug interactions.

Provider/Client Communication

Issues involving insurance or billing, appointment changes, and medication questions will be resolved during normal business hours, Monday through Friday 9 am – 7 pm, and will be handled through the Adler Psychiatry administrative team at 505-807-0055. Please allow up to 48 hours to return your call. **Important: If you are in a mental health or medical crisis, please call 911/988 or go to the nearest emergency room**. Another great resource is the Crisis Clinic which can be reached 24-hours a day for mental health crises at 866-4CRISIS (427-4747).

Fees/Billing

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out of network providers (such as Medicare). I recommend you contact your insurance provider to inquire about your out-of-network benefits if insurance reimbursement is an important issue.

My private pay fees are as follows:

$350 for a 50 minute session

$200 for a 20 minute session

When you receive your bill you may notice that the services I provide have different billing codes associated with them. Depending on the length of your session and complexity of care and changes in nomenclature you may see different codes for each session. Please contact Adler Psychiatry Billing forany questions at 505-807-0055.

Records Requests

Records requests will incur a clerical fee of $28.

Any other professional services that require longer than 10 minutes such as report writing, telephone conversations, preparation of treatment summaries, communication or coordination of care with family or other providers, or time spent performing any other services on your behalf will be charged $50 for each 10-minute increment. Insurance often does not cover these services. Fees are due at the time of service. NO medicolegal forms (FMLA, disability, legal, or other documents for outside entities) will be completed at initial appointments. An established relationship must be present prior to completing any documentation.

Legal Testimony

Though often unforeseen, legal matters requiring the testimony of a mental health professional can and do arise. Legal testimony may be damaging to the relationship between a client and his/her provider. As a result, I require that you employ independent forensic psychiatric or psychological services should this type of evaluation or testimony be necessary. If for any reason I am deposed or subpoenaed on your behalf and required to testify or appear in court, you will be responsible for my court fees at a minimum of $1,250 for a half day or $2,500 for a full day.

Client Rights

If you are unhappy with your treatment, I encourage you to discuss your concerns with me directly. Comments will be taken seriously and handled with respect. You may also request that I refer you to another mental health provider and are free to end treatment at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, or national origin.

I have the right to terminate our relationship under the following conditions:

1. When I believe that my services are no longer beneficial to you;
2. When I believe that another professional would serve you better;
3. When you have not paid for two sessions;
4. When you failed to keep your past two appointments without 48 business hours' notice or frequently miss appointments;
5. When you do not cooperate with the proposed treatment;
6. If you or your family member/significant other are hostile or aggressive to either my support staff or myself or cause any disruption in typical business activities.

Notice of Privacy Practices

This notice involves your privacy rights and describes how information about you may be disclosed, and how you can obtain access to this information.

Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my client, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis, progress and any associated diagnostic/therapeutic reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship, or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time by contacting the office.

Limits of Confidentiality

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization:

There are some important limits to my confidentiality – some exceptions created voluntarily, and some required by law. If you wish to receive mental health services from me, you must sign a form indicating that you understand and accept my policies about confidentiality and its limits. We can discuss these issues at any time during our work together.

I may use or disclose records about you without your consent or authorization in the following

circumstances:

- Emergency: If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.
- Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by New Mexico State law to report the matter immediately to the New Mexico of Social Services. Adult
- Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is being abused, neglected or exploited, I am required by New Mexico State law to provide relevant information to the New Mexico appropriate State organization(s).
- Health Care Oversight: New Mexico State law requires that licensed mental health providers report misconduct by a health care provider of their own or related professions. If you describe unprofessional conduct by another health care provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. New Mexico Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.
- Court Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization, or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can respond appropriately. However, while awaiting the judge's decision (should you elect to file a motion to quash or block the subpoena), I may be required to place said records in a sealed envelope and provide them to the Clerk of Courts. In civil court cases, therapy information may not be protected by client therapist privilege such as: child abuse cases, cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, there may be no statute granting therapist client privilege.
- Serious Threat to Health or Safety: If I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or law enforcement officer, whether you are a minor or an adult.
- Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

Patient's Rights and Provider's Duties

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to

limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voicemail messages.) To request alternative communication, you must make your request in writing to me, specifying how or where you wish to be contacted.
- Right to an Accounting of Disclosures: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization.
- Right to Inspect and Copy: In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I will charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychiatric notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.
- Right to Amend: If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. I will add your request to your health record. I may deny your request if you ask me to amend information that: 1) was not created by me; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.
- Right to a copy of this notice: You have the right to a copy of this notice. I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical/psychiatric information I already have about you as well as any information I receive in the future. The updated notice will contain the effective date and an updated copy will be provided to you.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

Acknowledgement

I hereby authorize Michelle I. Adler CNP, PMHNP-BC, to render psychiatric services to me.I am

aware of the 24-hour cancellation policy and associated fees.

I have received, read, and understood this Practice Agreement and Notice of Privacy Practices.

I authorize Michelle I. Adler CNP, PMHNP-BC, to release information to insurance carrier(s) and bepaid directly by insurance carrier(s) for services rendered. I acknowledge that I am responsible for all charges not paid by my insurance company including: copays, coinsurance, deductibles, insurance plan refusal to pay, and missed appointments/cancellation fees.

____ ____________________

Patient, Parent of Patient (if under 13 years of age), or Legal Guardian Signature

Date

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Medication History Consent

Pharmacy Medication History is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

By signing this consent form, you are giving your healthcare provider permission to collect and provide your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues.

Updated 12/1/2020

I give my permission to allow my provider at Adler Psychiatry to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Client's Printed Name: ________________________________

Client's Legal Representatives Name: ______________________________

If client is a minor / has a guardian:

Parent / Guardian Printed Name: ______________________________

The CLIENT MUST sign the consent if they are able to do so. The only exceptions are if the client is a minor, or has a legal document giving permission for someone else to sign on their behalf.

____ ____________________

Client / Clients LEGAL Representative / Parent or Guardian Signature   Date

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TELEHEALTH CONSENT, POLICY, and AGREEMENT

This form is in addition to the regular Adler Psychiatry, Policies, Agreement and Consent Form and Notice of Privacy Practices for Protected Health Information commonly known as HIPAA. You must sign allin order to participate in Telehealth sessions.

Required Information at Every Visit

- Name, location, and telephone number of the patient at time of session. This is to ensure that your practitioner is aware of alternative means of treatment should an emergency occur.
- Name, location, and telephone number of the provider at time of session.

Telehealth incorporates email, phone and video technology. This is to inform you about what you can expect regarding your participation in Telehealth.

Benefits: The benefits to Telehealth are:

1. The ability to expand your choice of service provider.

2. More convenient counseling/pharmacotherapy options.

3. Reduces the overall cost and time of treatment due to transportation to and from an office.

4. Ability to have real time monitoring and reduces the wait time for scheduling office appointments.

5. Increased availability of services to homebound clients, clients with limited mobility, and clients without convenient transportation options.

Limitations: It is important to note that there are limitations to Telehealth that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. Due to technology limitations we may not hear all of what you are saying and may need to ask you to repeat things.

2. Technology might fail before or during the telehealth session. Our second line of communication will be via telephone

3. Although every effort is made to reduce confidentiality breaches, breaches are possible

4. To reduce the effect of these limitations, we may ask you to describe how you are feeling, thinking, and/or acting in more detail than we would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

Logistics: When we provide phone/video treatment sessions, we will use your Patient Portal with us, or we can send you a link for the appointment, both are HIPAA compliant platforms. We expect that you are

available at our scheduled time and are prepared, focused and engaged in the session. We are calling you from a private location where we are the only person in the room, you also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where there are people who may hear you, we cannot be responsible for protecting your confidentiality.

Every effort MUST be made on your part to protect your own confidentiality. We suggest you wear a headset to increase confidentiality and also increase the sound quality of our sessions. Please know that we cannot guarantee the privacy or confidentiality of conversations held via phone, as phone conversations can be intercepted either accidentally or intentionally. Please assure you reduce all possibilities of interruptions for the duration of our scheduled appointment.

Please know that as a result of legal and ethical mandate we can only practice in the state(s) in which we are licensed. That means wherever you permanently reside we must be licensed. You agree to inform us if your treatment location has changed or if you have relocated your domicile to a different jurisdiction.

Connection Loss During Video Sessions: If we lose our connection during a video session, we will call you to troubleshoot the reason we lost connection and complete our session via phone if possible. If this is not possible, depending on when our loss of connection occurred, you will be asked to reschedule and/or be charged the full session rate

Connection Loss During Phone Sessions: If we lose our phone connection during our session, we will call you back immediately. Please also attempt to call us at 505-807-0055 if we cannot reach you. If we are unable to reach each other due to technological issues, we will attempt to call you two times via an alternate number. If we cannot reach you, depending on when our loss of connection occurred, you will be asked to reschedule and/or be charged the full session rate. The alternate number may show up as restricted or blocked please be sure to pick it up.

Safety: If we have concerns about your safety at any time during a phone/video session, we will need to break confidentiality and call emergency services in the area you are located at the time of the call and/or your emergency contact immediately.

Consent to Participate in Telehealth Sessions: By signing below, you agree that you have read and understand all of the above sections of Telehealth informed consent. You agree that you also understand the limitations associated with participating in Telehealth sessions and consent to attend sessions under the terms described in this document.

Updated 12/1/2021

Client's Printed Name: ______________________________

Client's Legal Representatives Name: ______________________________

If client is a minor / has a guardian:

Parent / Guardian Printed Name: ______________________________

The CLIENT MUST sign the consent if they are able to do so. The only exceptions are if the client is a minor, or has a legal document giving permission for someone else to sign on their behalf.

______________________________ ______________________________

Client / Clients LEGAL Representative / Parent or Guardian Signature — Date

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Health Information Portability and Accountability Act (HIPAA) Privacy Policy

This document contains important information about federal law, the Health Information Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that we obtain your signature acknowledging that we have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it.

Use and Disclosure of Protected Health Information:

● ***For Treatment –*** We use and disclose your health information internally in the course of your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.

● ***For Payment –*** We may use and disclose your health information to obtain payment for services provided to you as delineated in the Practice Agreement.

● ***For Operations –*** We may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

For HIV Disclosure- Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, public health authorities are authorized to collect and receive private health information "for the purpose of preventing or controlling disease" and in the "conduct of public health surveillance..." without patient or provider consent or authorization other than state or local public health law. *This clause authorizes providers to report HIV/AIDS cases to the HIV Epidemiology Program without obtaining patient consent and it authorizes health department personnel to review medical records and any other source of information needed to report the case.*

Any other disclosure of HIV-related information must be made on the *"HIPAA- Compliant Authorization for Release of Medical Information and Confidential HIV-Related Information".* State law prohibits any further disclosure of HIV-related private health information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

Client Rights:

● ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.

● ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.

● ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

● ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.

● ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.50 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

● ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if your request warrants amendment, and if we refuse to do so, we will notify you within 60 days.

● ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.

● ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of your PHI. On your request, we will discuss with you the details of the accounting process.

● ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.

● ***Right to Choose*** – You have the right to decide not to receive services with us. If you wish, we will provide you with names of other qualified professionals.

● ***Right to Terminate*** – You have the right to terminate therapeutic services with us at any time without any legal or financial obligations other than those already accrued. We ask that you discuss your decision with us before terminating or contact be made notifying us you are terminating services.

● ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we

will discuss whether or not we think releasing the information in question to that person or agency might be harmful to you.

Clinician Duties:

● We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We reserve the right to change the privacy policies and

practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will provide you with a revised notice.

Updated 12/1/2020

Client's Printed Name: ______________________________

Client's Legal Representatives Name: ______________________________

If client is a minor / has a guardian:

Parent / Guardian Printed Name: ______________________________

The CLIENT MUST sign the consent if they are able to do so. The only exceptions are if the client is a minor, or has a legal document giving permission for someone else to sign on their behalf.

______________________________ ______________________________

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FORMS POLICY

As a small practice with limited staff we have put the following policy in place for the filling out of disability forms. These may include but are not limited to: leave requests, short or long-term disability, SSI, Attorney forms, and FMLA forms.

- **The client must have been a client of this office for at least 12 months for long-term disability or SSI forms to be completed.** We are happy to provide your medical records, but we will not make the determination if you qualify for long-term disability.
- A client must have completed **two visits** for short term or FMLA forms to be completed.
- **Paperwork can take up to 14 days for completion.** It may be completed earlier, but it is done on a first come first served basis. Please understand it is difficult to rush this process due to the limited staff available to complete these forms.
- Clients must be compliant with on-going treatment (i.e. medication and appointment adherence).
- Clients must have seen the provider within the **last 30 days** to submit disability paperwork.
- **There is a charge to fill out these forms: $50 for every 10 minutes spent completing the form is due prior the form is returned to the client.**

Updated 12/1/202

Client Printed Name: ____

Clients Representative Printed Name: _________________________________

If client is a minor / has guardian:

Parent / Guardian Printed Name: ____

The CLIENT MUST sign the consent if they are able to do so. The only exceptions are if the client is a minor, or has a legal document giving permission for someone else to sign on their behalf.

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Client / Clients LEGAL Representative / Parent or Guardian Signature	Date

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No Show / Cancellation / < 24 Hr Reschedule Policy

(PLEASE READ CAREFULLY)

When you cancel or reschedule less than 24hrs prior to your appointment, or do not show up for your appointment, you prevent someone else from seeking/receiving treatment. You also place a financial burden on the practice. As a small practice we can't stay in business and provide care if patients (collectively and individually) repetitively miss, reschedule at the last minute, or continuously cancel appointments. We appreciate your understanding.

Multiple reminders utilizing different modalities are sent to you to remind you of your upcoming appointment. These reminders are verified with the software I use. Additionally when a client connects or disconnects from the video platform waiting room it is date and time stamped indicating when they connected and and the duration of the connection. This is the only method of verifying your presence for your appointment. Sadly, this method of verification is required, as dishonesty does occur, and as mentioned earlier, I cannot sustain my practice with no shows, and late cancellations. If you must cancel or reschedule an appointment, we require at least 24-hour notice (weekends not included). If your appointment is on a Monday, the cancellation must be made by the same hour on the preceding Thurs as we are closed on Fridays. We only offer video/online appointments at this time.

If you do not show up to your appointment, refill of your medication is at the provider's discretion.

TERMS FOR DISCHARGE FROM THE PRACTICE: Within one calendar year – Three (3) - less than 24hr cancellations, less than 24hr reschedules of your appointments, or failure to show to your appointment will be grounds for dismissal from the practice with referral to another practitioner.

________________________________ ________________

Client Signature Date