POLICY AND CONSENT FOR TREATMENT

Prism Reflections, LLC/Anew Psychiatry, LLC
1-803-201-3078 (p), 1-803-678-4260 (f)

Client Name___ DOB_____

This document contains important information about professional services and business policies, together with client/patient rights and responsibilities. Please read this required document in its entirety as you will be asked to sign it accordingly. It also contains summary information about HIPPA: the Health Insurance Portability and Accountability Act. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it or if you have not satisfied any financial obligation you have incurred.

Counseling/Therapy Process and Medication Services is a relationship that works in part because of the clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to facilitate and create change. Psychotherapy has both benefits and risks. Risks sometimes can include experiencing uncomfortable feeling such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. In time this can lead to benefits for individuals who undertake it. Therapy can lead to a reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. There are, however, no guarantees about the outcome. Psychotherapy does require active effort on your part. In order to be most successful, you will have to work on things that we discuss outside of sessions. An initial evaluation will be conducted. During that time, we will discuss if you would like to continue services and if this therapeutic relationship will be beneficial. Appropriate referrals will be made based on our decision at that time. Clients of Prism Reflections, LLC/Anew Psychiatry, LLC are required to be in therapy while receiving medication management. There are some situations where your provider may make an exception to your being in therapy while seeking medication treatment.

HIPPA is a federal law 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. HIPPA requires that I provide you with a Notice of Privacy Practices (the Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and healthcare operations. The Notice, which is on a separate page for you to read, explains HIPPA and its application to your personal health information in greater detail. Our practice is in general accordance with HIPPA policies. The law requires that I obtain your signature acknowledging that I have provided you with this information.

Confidentiality: Sessions are confidential and will be discussed with other people outside of your treatment team, and if needed it will only be done with your written permission. Please note that confidentiality is limited in the case of medical emergency, under court order/subpoena, or as required by law. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPPA. There are, however, several exceptions in which we are legally bound to take action, even though that requires revealing some information about a patient's treatment. If at all possible, we will make every attempt to inform you when these exceptions to the rule will need to be put into effect. The legal exceptions to confidentiality include, but are not limited to the following:

1. If there is good reason to believe that you are threatening to harm yourself or others. In this event I am required to seek hospitalization for you and/or contact the police, as well as additional means to provide protection.
2. If there is good reason to suspect or evidence of, abuse and/or neglect toward children, the elderly or disabled persons. In such a situation, I am required by law to file a report with the appropriate state agency.
3. In response to a court order or where otherwise required by law.
4. To the extent necessary for emergency medical care to be rendered.

Please note, there are times when we find it beneficial to consult with colleagues as part of our practice for mutual professional consultation. Your name and unique identifying characteristics will not be disclosed. The consultant is also legally bound to keep the information confidential.

Insurance and/or Managed Care: Although we accept select insurance plans, or out of pocket payments, we will request out-of-network authorization from insurance companies when appropriate. In seeking out-of-network approval, insurance companies will likely require that we release certain protected health information to them including the diagnosis, treatment plan, and progress. Therefore, an initial consultation is required prior to making any request. If approval is granted, our office will provide you with a receipt that may be submitted to your insurance company for reimbursement.

Appointments and Fees: Cancellations or changes of appointment time must be made at least 24 hours in advance in order for us to best serve our clients. Failure to keep your appointment or a late cancellation notification will result in your being charged the full fee for that scheduled appointment. Insurance will not cover any costs related to your not attending an appointment. Initial consultations are scheduled for up to 1 hour sessions and all appointments following are scheduled for up to 30-minute sessions. All fees will be discussed with you prior to your initial consult. Our office prefers to handle all billing via credit card. We will automatically bill your credit card on file for your session unless other arrangements are made. We do charge all appointment fee's within 24 hours of your appointment. In the event a

balance is accrued and no payment is received, the practice reserves the right to seek remuneration through available legal means including, but not limited to, the retention of a collection agency.

Refill requests must be made 7 days in advance to your pharmacy. Clients are encouraged to keep all appointments, refill requests for controlled substances may not be honored unless the client has been seen in our office within 30 days.

Emergencies: If you are in a crisis call 911, crisis line or proceed to the nearest emergency room, then reach out to your provider once you are safe. We are unable to accept emergency calls with our office.

Professional Records: We are required to keep appropriate records of the services provided. Although psychotherapy/medication management often includes discussion of sensitive and private information, in most cases, brief records are kept that you have been here, what was done in session, and a mention of the topics discussed. Your records are maintained in a secure locked location and/or in an approved web-based behavioral Practice Management System that has been chosen as having met security protocol standards set forth by HIPPA.

Social Media & Other Forms of Communication: There will be no connection created on any internet social media account such as Facebook, Linked In, etc. With your permission, we may communicate with you via e-mail, text, or Electronic Health Record. However, it is important to note that none of these forms of communication are completely secure.

By signing this document, I acknowledge that I have read the above, agree with all policies set forth, and give informed consent to treatment services. You are also consenting to the use of telepsychiatry for your psychiatric appointments.

I also acknowledge that I have had the opportunity to read the separate Privacy Practices/HIPPA disclosure and that I may ask for printed copies of these forms. If treatment involves your minor child, you as parent/guardian give consent and agreement to services for your child as set forth in this document.

Client Signature_____Date_____

Provider Signature_____Date_____