New Beginnings Therapy Inc

CONSENT FOR CARE & TREATMENT

Introduction

Welcome to **New Beginnings Therapy Inc**! This informed consent document is intended to give information about our therapy services. This is a legal document; read it carefully before signing. Please take the time to read the **New Beginnings Therapy Inc** Outpatient Service Contract. If you have any questions about signing this document and/ Or would like a copy of this document please ask your therapist.

Nature of Therapy

I understand that there may be both risks and benefits associated with participation in therapy. Therapy may improve my ability to relate to others, provide a clearer understanding of myself, my values, and my goals, and an ability to deal with everyday stress. Although therapy can be beneficial to many people, it may not be helpful for everyone. Therefore, it is essential that you discuss any questions or discomfort you might have with your therapist.

Confidentiality

I understand that confidentiality is maintained in accordance with the ethical guidelines and legal requirements of the profession. I understand that no records or information about me will be released from **New Beginnings Therapy Inc** without my permission, except under certain circumstances:

If I present a serious danger to myself or another person. If I was abused (physically or sexually) or neglected as a child, and if other minor children are currently at risk of being abused or neglected by the person(s) who abused me. If I am under 18 years of age and disclose abuse or neglect to my counselor. If your therapist learns that an elderly person, dependent adult, or minor child is being abused or neglected. If I have physically or sexually abused a minor child and that child or other minor children are at risk of ongoing abuse. If a valid subpoena is issued for my records, or my records are otherwise subject to a court order or other legal process requiring disclosure.

Attendance Policy

I agree I will notify my therapist AT LEAST 24 HOURS of my scheduled appointment in advance if I know I will miss a session. I understand that if I do not show for therapy and do not call to reschedule with 24 hour notice, I will be billed $100 for a missed session.

I, the undersigned, do hereby agree and give my consent for **New Beginnings Therapy Inc** to furnish medical care and the treatment to considered necessary and proper in diagnosing or treating his/her physical and mental condition.

_____ _____

Patient/Guardian/Responsible Party Date

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and third party payors. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

_____ _____

Patient/Guardian/Responsible Party Date

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for the payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to **New Beginnings Therapy Inc**.

The above may not apply for those patients that are considered Worker's Compensation or who have benefits with a balance billing contract, such as an HMO. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

New Beginnings Therapy Inc verifies benefits as a courtesy to you. However, we do not accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefit plan.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all cost of collecting monies owed, including court cost, collection agency fees, and attorney fees.

INFORMATION PRIVACY: **New Beginnings Therapy Inc** will use and disclose your personal health information to treat you and to receive payment for the care provided, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____

Patient/Guardian/Responsible Party Date

Background Information

Patient's Name:_____

Primary Language Spoken: _____ Date Of Birth:_____Marital Status: _____ Sex: _____ M _____F

Address:_____

City_____ State_____ Zip Code_____

Email Address:_____

Home Phone:_____Cell Phone:_____ Preferred Method of Contact:_____

Emergency Contact and Phone Number:_____

Primary Insurance Company: _____

Phone Number of Ins Company: _____Policy #: _____Group #:_____

Primary Policy Holder's Name: _____ Primary Policy Holder's DOB: _____

Relationship to Client: _____

Psychiatric Medication Management (if applies):

Current Prescriber: _____ City/State:_____

Phone:_____ Fax:_____

Prescription/Non-Prescription medication(s) you are currently taking or N/A:

Name of Medication(s)/Dosages: _____

New Beginnings Therapy Inc

1615 S Congress Ave, Ste 103, Delray Beach, FL 33445 / 406 Parker Ivey Drive, Greenville, SC 20607

Office: (561) 917-9997 Fax: (561) 455-9988

Coordinating your treatment with your doctor allows us to provide you with the best care. Please provide your Primary Care Physician (PCP) or Psychiatrist Contact information and sign below to indicate your consent.

Name of Doctor: _____

Doctor's Address: _____

Doctor's Office Phone: _____ Doctor's Fax: _____

Please Initial One:

_____ I give consent to coordinate my care with the above doctor. I can rescind this consent at any time.

_____ I do not wish for you to coordinate my care with my Doctor.

Client Printed Name: _____

Client's Signature: _____

Date: _____

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CREDIT CARD INFORMATION

PATIENT NAME:_____

Name (Please Print Name as it appears on the Credit Card):_____

Street Address:_____

City: _____ State: _____ Zip Code: _____

Credit Card Type:

_____ American Express _____ Discover _____ Master Card _____ Visa

Credit Card Number:_____

Expiration Date: _____ CVV Number: _____ (3/4 digit Security Number on the back of the card)

***I authorize my Credit Card to be used as payment for services rendered and/ or in the event

of not canceling **within 24 hours**, I authorize a $ 100.00 charge:

_____ _____

Signature (Authorized Card Holder) Date

New Beginnings Therapy Inc

Consent to Participate in Telehealth Assessment/Treatment

Telemental healthbased services require access to certain services and tools. In order to participate in telemental health services, patients need to give their consent with signatures. Security, benefits, and risks of the service are explained below in detail.

What is Telemental Health?

Telemental Health is an online therapy service that provides psychological counseling and support to the patients via the internet, video conferencing, phone call and chat.

Benefits and Risks of Telemental Health

Telemental Health services are using the internet and video conferencing software. Because during appointments, internet technology is used, there may be a disconnection and other difficulties that are the direct result of the low internet speed. Telemental Health services enable patients and specialists to communicate if patients have barriers such as transportation or illness.

Communication Plan

Desired communication for Telemental Health services is videoconferencing technology. Hence, at first, specialists/therapists try to provide services on videoconferencing software during the appointment date and time. If this is not successful because of the low quality of the video, low internet speed, or any other technical difficulties, therapists will call patients at the phone number. It is advised to patients to connect 5-10 minutes prior to the appointment time and check whether the internet speed, webcam, and microphone work properly as expected.

Security and Privacy

The software used in online appointments is protected securely. If patients have concerns about the

security and records that will be part of the electronic record system, it is advised that patients let the

therapists know the concerns. Video or audio sessions will not be recorded.

***I have read this document carefully, and understand the risks and benefits of the telehealth consultation/treatment and have had my questions regarding the technology answered. I hereby consent to participate in a telehealth visit under the terms described herein.

_____

Patient/Parent/Guardian Signature

_____

Date

HIPAA Notice of Privacy Practices

New Beginnings Therapy, Inc

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

The terms of this Notice of Privacy Practices (“Notice”) apply to New Beginnings Therapy, Inc, its affiliates and its employees. New Beginnings Therapy, Inc. will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by New Beginnings Therapy, Inc. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act (“HIPAA”). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address shown at the bottom of this notice.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION: Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include types of therapy methods/interventions, medications, medical history, mental health history, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care. Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated,

suicidal/homicidal, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information. Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below. Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

◯ Any purpose required by law;

◯ Public health activities such as required reporting of immunizations, disease, injury,

birth and death, or in connection with public health investigations; ◯ If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;

DISCLOSURES REQUIRING AUTHORIZATION: Psychotherapy Chart: We must obtain your specific written authorization prior to disclosing any psychotherapy content of your chart unless otherwise permitted by law. However, there are certain purposes for which we may disclose your chart information, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law,

(3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public. Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value. Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:

◯ To the Food and Drug Administration to report adverse events, product defects, or to

participate in product recalls; ◯ To your employer when we have provided health care to you at the request of your

employer; ◯ To a government oversight agency conducting audits, investigations, civil or criminal

proceedings; ◯ Court or administrative ordered subpoena or discovery request;

○ To law enforcement officials as required by law 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; ○ To coroners and/or funeral directors consistent with law;

○ If necessary to arrange an organ or tissue donation from you or a transplant for you;

○ If you are a member of the military, we may also release your protected health

information for national security or intelligence activities; and ○ To workers' compensation agencies for workers' compensation benefit determination.

(561) 917-9997. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each

request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If

○ Public health activities;

○ Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes; ○ Treatment and payment purposes;

○ Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence; ○ Payment we provide to a business associate for activities involving the exchange of

protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities; ○ Providing you with a copy of your health information or an accounting of disclosures;

○ Disclosures required by law;

○ Disclosures of your health information for any other purpose permitted by and in

accordance with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or ○ Any other exceptions allowed by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION: Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" by calling the Privacy Officer at

an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" by calling the Privacy Officer at (561) 917-9997.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid New Beginnings Therapy, Inc. in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address shown at the bottom of this notice.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, Washington, D.C. 20201, calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. There will be no retaliation for filing a complaint.

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the Mobile Medical Health Privacy Officer by phone at (561) 917-9997 or at the following address:

New Beginnings Therapy, Inc, 1615 S Congress Ave, Ste 103, Delray Beach, FL 33445 -OR- 406 Parker Ivey Dr, Greenville, SC 29607.

***I have read and understand the HIPAA Policy.

Signature of Patient or Guardian: _____

Date:_____