Telemental Health Informed Consent Form

I _____ hereby consent to engaging in telemental health with the therapist of Inspirational Behavioral Healing, Inc listed below as part of my psychotherapy. I understand that "Telemental Health" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of mental health data, and education using interactive audio, video, or data communications. By this means of experiencing technical problems, and not being able to complete electronically, my delivery package for treatment permit and medical record authorizations and authorized forms for the mental health service provided, I authorize IBH so that they can sign on my behalf, fully understanding and with all my ability to make decisions that are signed in my favor all documents.

I understand that I have the following rights with respect to telemental health:
(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical and mental health information also apply to telemental health. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards self, and/or an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemental health interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemental health, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical or mental health information could be disrupted or distorted by technical failures; the transmission of my medical or mental health information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or limited ability to respond to emergencies. In addition, I understand that telemental health-based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to as a therapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases may even get worse.

(4) I understand that I may benefit from telemental health, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical and mental health information and copies of medical records in accordance with United States federal Laws and jurisdictions.

(6) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in the event of an emergency. I understand it is my responsibility to also seek appropriate emergency services such as 911 and/or local crisis services if I am experiencing a mental health crisis. I agree to inform my therapist of the address where I am located at the time of the session.

(7) The professional or primary therapist may in turn terminate such help when he/she understands that it is not beneficial and/or necessary or refers me to another specialist for a more appropriate follow-up. In case of transfer of communication styles and possibly conflicting emotions during the therapeutic and counseling relationship, the therapist and counselor will stop the follow-up processes and will be appropriately referred to another professional of your choice. Any information provided by me will be confidential and will be disclosed to others only with my prior consent, except if it would endanger my life or the lives of others, or in accordance with the laws governing federal statutes and laws in each State and jurisdictions.

I have read and understand the information provided above. I have discussed it with my therapist, and all of my questions have been answered to my satisfaction.

_____	_____	_____
Signature of Patient/Parent/Guardian	Date	If signed by other than patient indicate relationship

_____	_____
Printed Name of Therapist	Signature of Therapist

Inspirational Behavioral Healing
Inspirational Advisory Consulting
Nationwide Services
(771) 242-5111

7901 4th St N Ste 300
St Petersburg FL 33702
(860) 707-7242

INSPIRATIONAL ADVISORY CONSULTING LLC
INSPIRATIONAL BEHAVIORAL HEALING

TELEHEALTH INFORMED CONSENT

Patient Name: _____Date of Birth: _____

Telehealth is a form of telemedicine that allows clients to access behavioral health care using electronic communications to enable health care providers at different locations to share individual client medical information for the purpose of improving client care. The information may be used to diagnose & treat, psychotherapy, follow-up and/or client education. By this means of experiencing technical problems, and not being able to complete electronically, my delivery package for Treatment Permit and medical record authorizations and authorized forms for the mental health service provided, I authorize IBH so that they can sign on my behalf, fully understanding and with all my ability to make decisions that are signed in my favor all documents.

Purpose

The purpose of this form is to obtain your consent to participate in our telehealth services.

Benefits of Telehealth

- Improved access to psychotherapy/counseling care by enabling a client to remain at his/her own home or office.
- More efficient behavioral evaluation and management.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by mental health professionals.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.

Medical Information & Records

All existing laws regarding your access to medical information and copies of your medical records apply to telehealth services. Please note that telecommunications are not recorded or stored.

Confidentiality

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

By signing below, you are acknowledging that you agree to participate in telehealth services.

Signature of Client or Authorized Legal Representative: _____Date: _____

Printed name of Client or Authorized Legal Representative: _____

INSPIRATIONAL ADVISORY CONSULTING LLC
INSPIRATIONAL BEHAVIORAL HEALING

PATIENT CONSENT FORM

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I understand this information will be used to provide comprehensive and coordinated services. I agree that a copy of this authorization will be as valid as the original. I understand this authorization will expire 30 days from the date of discharge from the practice or one year from the date of my signature. I give this consent freely and voluntarily and understand that refusal to grant authorization will not prevent me from utilizing services upon acceptance to ***Inspirational Advisory Consulting LLC & Inspirational Behavioral Healing.*** By this means of experiencing technical problems, and not being able to complete electronically, my delivery package for Treatment Permit and medical record authorizations and authorized forms for the mental health service provided, I authorize IBH so that they can sign on my behalf, fully understanding and with all my ability to make decisions that are signed in my favor all documents.

I understand that I may revoke this consent at any time prior to the release of the above information by making the request in writing to ***Inspirational Advisory Consulting LLC & Inspirational Behavioral Healing*** but that any such revocation will not apply to information already released while this authorization was in effect. I understand that information, once disclosed to others, may be re-disclosed to entities not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and therefore, may no longer be protected by HIPAA. The confidentiality of this record is required under Federal Regulations & General Statutes at any jurisdiction and State as well as Title 42 of the United States Code. This material cannot be transmitted to anyone without your written authorization, as provided for in these statutes.

In case the need arises for a face-to-face session or therapy in the different modalities, the cost of the service being the therapist outside the office area or the State (We have the services of locations in all States and jurisdictions) the service will be a private one with an amount of $200 per-hour and the client will be responsible for the costs of travel and mobilization of the professional to his area of preference. Time away from the visitation line will be divided according to the session cost of $200 hour fraction within working hours (every 15 minutes $50 after the first hour invoiced) and ($350.00 for each hour or time fraction of expert consultation will be payable before the consultation begins with time of only one (1) hour) and if the need for interventions outside working hours or Sundays arises, the session cost will be $300 Fraction hour for every 15 extra minutes $75 every 15 minutes after the first hour billed. This first visit is for your initial interview to outline the treatment (counseling or therapy) to be followed, any additional clinical/evaluative procedures would accrue additional costs according to the need of each case payable before beginning your evaluation process. It is important that you are committed as a client/advised to make correct use of the treatment (Counseling and Therapy).

All online services require payment for each procedure in advance for the reservation of your space and appointment for your therapy and counseling. As part of the various payment platforms, it is important that you make the payment on time before proceeding with your booked appointment. You, as a signatory of this consent, declare your mental state consistent and capable of making your own decisions, without any legal guardian (in case of a guardian you must present your official document by a court evidencing such incapacity) to mediate your decisions and fully understand without any doubt everything written and discussed here before starting with the counseling services.

I hereby fully understand the services that will be offered to me by relieving Inspirational Behavioral Healing/Inspirational Advisory Consulting LLC of any past, present and future actions that may arise in relation to the services that will be provided to me and any legal, administrative and/or extrajudicial action related to the services. In the case of counseling and couples therapy, they are guided on the possibility of entering deep themes and dynamics in sharing and the conjugal relationship where they can intervene in affective, sensitive areas that not every patient can face and manage when talking and confessing extramarital events, sexual abuse, among others. It is necessary to let it be known if they want group or individual intervention for each of the parties. Due to the use and varied techniques within Professional Counseling & Clinical Traumatology, inventories, questionnaires, tests in the areas of personality, emotional, intelligence, behavioral and cognitive are used to establish diagnoses and a conceptualized and outlined treatment plan for your condition or complaint according to your consultation. It is important that you understand that because of what is presented in your consultation, you may be recommended to use these instruments to establish a treatment (Counseling and Therapy) appropriate to your diagnosis as well as laboratory analysis by medical order of your preference with your family doctor to rule out physiological pathology.

INSPIRATIONAL ADVISORY CONSULTING LLC
INSPIRATIONAL BEHAVIORAL HEALING

FINANCIAL POLICY

We, the staff at Inspirational Behavioral Healing & IAC LLC, thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs, and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our clients' financial responsibilities is vital to that provider-client relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact the office manager. We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Fees and Payments

Please understand that payment for services is an important part of the provider-client relationship. We make payment as convenient as possible **by accepting cash, MasterCard, Visa, Zelle, Stripe and other alternatives available at the moment**. (A service fee of 3.8% will be charged for all payments with debit, credit and other cards or electronics methods payments; **the cost per hour private pay will be $200**)

Payment for services will be due at the before time of service including any co-insurance, co-pay or deductible amount not covered by the insurance according with the eligibility of the patient or private pay at the moment book the appointment before the session. A service fee of $20.00 will be charged for all co-payments not paid at the time of service. If there is a remaining balance due after your visit, we will charge the credit card on file. Please make sure that any remaining balance has been paid prior to your next visit. Additional fees may be incurred as a result of email communications and/or letter writing for occupational, educational, and other general purposes.

Cancellation Policy and Missed Appointments

We have a 48-hour cancellation policy. Since your scheduled time is reserved for you, if an appointment is not canceled within 48 hours, you will be responsible for **the full appointment fee**. This will not be covered by your insurance company. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

I have read and understand the above financial policy. I agree to assign insurance benefits whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Signature of Client or Authorized Legal Representative: _____ Date: _____

INSPIRATIONAL ADVISORY CONSULTING LLC
INSPIRATIONAL BEHAVIORAL HEALING

GENERAL OFFICE POLICY

Appointments and Confirmation calls:

- It is the clients' responsibility to keep their appointments or cancel them within 48 hours. You will receive a courtesy text message to remind you 48 hours prior to your appointment. Please reply to confirm the appointment. If you are unable to make the appointment, please contact us to reschedule. Inspirational Behavioral Healing charges for all missed late, or canceled appointments that are not canceled within the 48-hour period.
- It is our policy to discharge clients who miss or late-cancel three appointments in a six-month period, even if these incidents are not consecutive.
- Clients who are not seen in more than a six-month period of time, without provider approval will be considered discharged from the practice. In order to reschedule any further appointments, the client will be directed back to intake to assess client appropriateness. It is not guaranteed that the client will be accepted into practice.

Paperwork/Forms:

- If you require a letter, form or document to be completed, we have ten business days to complete your requests.

Medical Records Request:

- If you request records of any kind, we have 30 days to complete your requests.

Signature of Client or Authorized Legal Representative: _____

Printed name of Client or Authorized Legal Representative: _____ Date: _____

INSPIRATIONAL ADVISORY CONSULTING LLC
INSPIRATIONAL BEHAVIORAL HEALING

PATIENT INTAKE FORM

If you are seeking to become a new client, please complete this form and bring it to your appointment or email it to: ibhalternative@gmail.com / fullsanationmind@gmail.com

Section I - **PATIENT INFORMATION**:

First Name: _____Last Name: _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____Cell Phone: _____

Social Security #: _____Date of Birth: _____

Marital Status: ☐Single ☐Married **Gender:** ☐Male ☐Female ☐Other

Are you currently employed? ☐YES ☐NO Occupation: _____

Emergency Contact Name: _____ Relationship: _____

Contact Phone: _____ if okay to release information, consent must be signed.

Form Completed By:

☐Self ☐Parent ☐Legal Representative ☐Spouse ☐Other

Section 2 - **INSURANCE INFORMATION:**

Primary Insurance

Subscriber's/ Policy Holder's Name: _____ Date of Birth: _____

ID# (on card):_____Sponsor SS#_____

Signature of Client or Authorized Legal Representative: _____ Date: _____

INSPIRATIONAL ADVISORY CONSULTING LLC
INSPIRATIONAL BEHAVIORAL HEALING

Section 3 -**CURRENT MEDICATIONS & DOSES**

Please list all Prescription and Over the Counter medications that the client is currently taking.

Medication	Dose	# times per day

ALLERGIES:

Please list all medication allergies and the reactions of the client.

Allergy	Medication	Reaction

Signature of Client or Authorized Legal Representative:_____Date:_____

INSPIRATIONAL ADVISORY CONSULTING LLC
INSPIRATIONAL BEHAVIORAL HEALING

Section 4 - **DEPENDENCE & ILLICIT SUBSTANCE ABUSE HISTORY:**

Do you smoke? ☐ Yes ☐No If yes, how many packs a day & for how long? _____

If you are a former smoker, how long has it been since you quit? _____

Do you drink Alcohol? ☐Yes ☐No Type: ☐ Beer ☐ Liquor ☐Wine

Frequency: ☐Socially ☐Minimally ☐Infrequently ☐Frequently How many: _____

Drug Use: ☐Yes ☐No If yes, what type: _____

Other Habits: ☐Yes ☐No If yes, please specify: _____

Signature of Client or Authorized Legal Representative:_____Date:_____

INSPIRATIONAL ADVISORY CONSULTING LLC
INSPIRATIONAL BEHAVIORAL HEALING

PATIENT CONSENT FORM
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: _____DOB: _____ SSN: _____ - _____ - _____

I understand that the information to be exchanged may contain protected substance abuse, psychiatric, and confidential HIV-related information (Protected Health Information). By this means of experiencing technical problems, and not being able to complete electronically, my delivery package for Treatment Permit and medical record authorizations and authorized forms for the mental health service provided, I authorize IBH so that they can sign on my behalf, fully understanding and with all my ability to make decisions that are signed in my favor all documents.

I authorize Inspirational Behavioral Healing to

Release Protected Health Information to *and/or* **Obtain** Protected Health Information from:

Facility/Agency/Person: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____Fax Number: _____

Protected Health Information that may be used or disclosed includes: *(Check all that apply)*

☐Complete Medical Record
☐Mental Health Information
☐Drug/Alcohol related information
☐Complete Medical Record
☐IAP "Treatment plan"
☐HIV/AIDS relation information
☐Referrals
☐Initial Assessment
☐Progress Notes
☐Discharge Summary
☐Other (specify):

Date of treatment to be released / obtained:

☐All Dates of Service ☐Specified Dates
Start Date: _____ End Date: _____

The information released under this authorization will be used for the following purposes: *(Check all that apply)*

☐Assess for intake purposes
☐Provide Treatment
☐Review History
☐Coordinate Care
☐Review for Services
☐Other (specify):_____

HEALTH SCREEN

Date: _____ Client name: _____ D.O.B. _____

Allergies

Do you have any allergies? ☐ Yes ☐ No

If yes, please list below:

Food: _____

Medication (Including OTC or herbal): _____

Environmental: _____

Medical and Physical Health

Please include physical complaints that may interfere with the person's functioning.

Describe current health: _____

_____

_____

Pain Screening

Is the person experiencing pain currently? ☐ Yes ☐ No

Has the person experienced pain in the past few *m*onths? ☐ Yes ☐ No

If yes, please describe the type, frequency, duration, intensity, identified cause, any limitations to functioning and what helps relieve the pain:

_____

Nutrition Screening

Special diet? ☐ Yes ☐ No Follow diet? ☐ Yes ☐ No

Medications affecting nutritional status? ☐ Yes ☐ No

Change in appetite? ☐ Yes ☐ No Weight gain/loss of 10 pounds? ☐ Yes ☐ No

_____Binging _____Purging _____Use of Laxatives _____ Intense focus on weight, body size, calorie intake or exercise.

Describe current beliefs, perceptions, attitudes, and behaviors regarding food: _____

_____

Physical Health Summary and Recommendations

If person has not had a physical exam in past year, or if person reported pain without a determined cause, or if person has reported eating disorder behaviors that are not being medically followed:

_____Recommended physical exam _____Person declined recommendations of exam _____Recommended referral for nutritional assessment _____Requested permission to contact primary care provide*r*

Medication Summary

Is the person served currently taking medications? ☐ Yes ☐ No

(if yes, enter on Comprehensive Assessment)

Authorization for Release of Information

Two-Way

Name:_____ Other Name (s):_____

Address:_____ Phone:_____

Date of Birth:_____

I authorize Inspirational Behavioral Healing to receive and release Information from or to the person, agency or facility named below, either verbally or in writing, as indicated in this authorization.

Name: _____ Phone:_____

Street:_____City/Town:_____ Sate:_____ Zip:_____

IBH Contact Information:

Name:_____ Phone:_____

Address:_____

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request.

Specify Information to be released:

☐Entire Record	☐Discharge Summary	☐Evaluations	☐Treatment Plans
☐Admission Documentation	☐Transfer Summary	☐Assessments & Tests	☐Psychotherapy Notes
☐ISPs & IAPs	☐Physical Exam	☐Lab Reports	☐Psychiatry Notes
☐Neuropsychic Testing	☐Consultations (Include name of consultant)		☐Other (specify below)

_____

_____

Purpose for the authorization (must check one):

☐The subject of the information or Personal Representative initiated the authorization (specific purpose not required)

Or

☐Coordinate care ☐Facilitate billing

☐Referral ☐Obtain Insurance, financial or other benefits

Other purpose (please specify):_____

A copy of this authorization shall be considered as valid as the original.

Authorization for Release of Information Two-Way (continued)

Name of person/facility/agency/other than IBH to receive or release Information: _____

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to IBH at IBH address identified on page two. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire (specify a date, time period or an event) or, if nothing is specified, it will expire when I am no longer receiving services from IBH. I understand that once the above information is disclosed to a person, facility or agency outside IBH, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to receive treatment or services from IBH and/or the other named person, facility or agency. However, lack of ability to share or obtain information may prevent IBH, and/or the other named person, facility or agency, from providing appropriate and necessary care. By this means of experiencing technical problems, and not being able to complete electronically, my delivery package for Treatment Permit and medical record authorizations and authorized forms for the mental health service provided, I authorize IBH so that they can sign on my behalf, fully understanding and with all my ability to make decisions that are signed in my favor all documents.

_____ _____

Your signature or Personal Representative's signature Date

_____

Print name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent)_____

Specially Authorized Releases of Information (please initial all that apply)

_____To the extent that my medical record contains information concerning alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I specifically authorize release of such information.

_____To the extent that my medical record contains Information concerning HIV antibody and antigen testing that is protected by MGL c.111 §70F, an HIV/AIDS diagnosis or treatment; I specifically authorize disclosure or such Information.

_____ _____

Your signature or Personal Representative's signature Date

Instructions:

1. This form must be completed in full to be considered valid.
2. Distribution of copies: original to appropriate IBH record; copy to Individual or Personal Representative; copy to person/facility/agency making request.

Medical Information Request and
Health Information 2- way Disclosure Authorization

Provider Name:/Title: _____

Client Name: _____ **DOB:** _____

IBH Primary Care encourages coordination of care between behavioral health providers and primary care providers and asks permission to communication with client's primary care physician.

One box must be checked:

☐I hereby authorize **IBH Primary Care** to receive and disclose protected health information from or to my primary care provider named below, either verbally or in writing, as indicated in this authorization. A copy of this authorization shall be considered as valid as the original.

Physician name:_____ Clinic/Hospital name:_____

Phone number:_____ Address and zip code:_____

☐I **do not** authorize **IBH Primary Care** to receive and disclose protected health information form or to my primary care provider.

Specific Description of the Information to be disclosed:

☐Diagnosis ☐Medications ☐Any information relevant to Psychotherapy

I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. Other limitations on my right to revoke this authorization may be found in my provider's Notice of Privacy Practices.

Medical Information Request:

IBH Primary Care advocates annual physical examinations for adults and well child visits for children and asks permission to request a copy of the most recent physical examination report. By this means of experiencing technical problems, and not being able to complete electronically, my delivery package for Treatment Permit and medical record authorizations and authorized forms for the mental health service provided, I authorize IBH so that they can sign on my behalf, fully understanding and with all my ability to make decisions that are signed in my favor all documents.

One box must be checked

☐I/My child have/has already had a physical examination within the past 6 months and hereby sign a Release for my primary care provider to make a copy of this report available to **IBH Primary Care.**

☐I/My child have/has not had a physical examination within the past 6 months, but I will arrange to do so, and hereby sign a release for my primary care provider to make a copy of this report available to **IBH Primary Care.**

This authorization will expire on Date:_____. OR one year from the signature date indicated below.

Client Signature:_____ Date:_____

Parent/Guardian name:_____ Relationship:_____

Parent/Guardian signature:_____ Date:_____

Medical Information Request and Health Information 2- way Disclosure Authorization (continued)

I further understand that my records are protected under federal confidentiality regulations (42 CFR, Part 2), confidentiality of alcohol and drug abuse treatment. The recipient of drug and/or alcohol abuse information disclosed as a result of this authorization will need my further written authorization to re-disclose this information.

☐I hereby authorize disclosure of information related to alcohol or drug abuse in my record.

☐I hereby authorize disclosure of information related to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

Client Signature:_____ Date:_____

Parent/Guardian name:_____ Date:_____

Consent for Treatment and Receipt of:

- ✓ **Client Rights**
- ✓ **Notice of Privacy Practices**
- ✓ **Therapy Attendance Policy**
- ✓ **After Hours Information**

Client Name:_____

DOB:_____

I hereby consent to become a client of Inspirational Behavioral Healing. By this means of experiencing technical problems, and not being able to complete electronically, my delivery package for Treatment Permit and medical record authorizations and authorized forms for the mental health service provided, I authorize IBH so that they can sign on my behalf, fully understanding and with all my ability to make decisions that are signed in my favor all documents.

Client Rights

Notice of Privacy Practices

Therapy Attendance Policy

After Hours Information

Client signature:_____ Date:_____

Parent/Guardian name:_____ Relationship:_____

Date:_____

Client Policy and Rights

This policy establishes standards and procedures to ensure that IBH and its Programs and Facilities respect, support and protect the fundamental human, civil, constitutional and Statutory rights of Clients. All Clients have the right to be free from any unlawful discrimination, including, but not limited to, discrimination on the basis of race, creed, national origin, religion, gender, sexual preference, language, age, veteran's status, disability, HIV status or ability to pay.

The Right to Treatment

It is the responsibility of IBH and its Facilities and Programs to ensure that Clients may exercise their Human Rights without harassment or reprisal, including the denial of appropriate and available treatment, services, its facilities, and programs must ensure that their staffs comply with all applicable regulations, policies and procedures. Clients will have the freedom to choose their Health Care Provider.

The Right of Informed Consent

In order to protect the privacy of patients, Federal law Nationwide specifically states that the medical records of a patient in any health care facility or under a physician be kept confidential. The law also requires that the information of Medicaid and Medicare recipients must be kept confidential unless disclosure is directly connected to the administration of the program.

Required reporting of medical data that identifies a patient may not be disclosed, except if the information is being used to prevent the spread of disease, for research purposes and/or the patient has given written consent to its use. The Commissioner of Public Health can disclose medical information submitted to disease specific registries must remain confidential and de-identified.

Insurance companies also take steps to ensure the confidentiality of an individual's information. For example, an individual must sign a release before the insurer can release any medical or treatment information for insurance determinations.

ATTENDANCE POLICY

Appointment no shows create a disruption in Therapy. Regular attendance is an extremely important part of treatment. All cancelled appointments must be made within 48 hours of the scheduled appointment, if the appointment is not cancelled within 48 hours it will then be considered a no show. Three no shows will result in your case being closed. If a client has been closed for no shows, or any other reason, the client case will also be closed.

If a client has been closed, at that time the Clinical Director will provide a list of local providers.

I fully understand the Attendance Policy.

Notice of Privacy Practices:

Our commitment to your privacy

IBH will maintain the privacy of your protected health information (PHI). In this Notice, PHI means health information which may identify you and which relates to past, present, or future physical and/or mental health.

We may use your PHI in the following ways:

Treatment

We create records regarding your treatment and may disclose your PHI to a physician or other healthcare provider with whom you receive services.

Payment

We may use your PHI to operate our business and to assess the quality of care and outcomes of your case.

Written authorizations

We will obtain your written authorization before disclosing your PHI. You may withdraw or revoke this authorization in writing at any time. We will then stop using or disclosing your PHI, except to the extent that we have already taken action upon that authorization.

Your Rights

You have the right to inspect and copy your protected health information. This usually includes medical and/or billing records. You must ask us in writing and agree to be responsible for a reasonable fee before we provide you with your copy. You may ask us to provide your electronic records in electronic format. If we are unable to provide you with the record in the format you request, we will provide it in a form that works for you and our office. You may also ask us to transmit your record to a specific person or entity via email if a) you provide the email address in writing and b) sign a statement that you fully understand that email comes with inherent risks that we cannot prevent and for which our offices are not responsible. Under certain circumstances, your provider may not allow you to see certain parts of your record. You may ask that this decision be reviewed by another licensed professional.

You have the right to request a restriction on your protected health information. This means you may ask us not to use or disclose all or part of your protected health information for the purpose of treatment, payment or healthcare operations. We will consider your request carefully and may honor reasonable requests where possible. We are not required to honor all requests.

If you have received services from our healthcare providers or hospitals and do not wish to share your health information with your insurer, we must honor your request if you have paid out of pocket in full for your services and as long as sharing your claim is not required by law. Please discuss this request with us.

You may also ask if any part or your protected health information is not disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must tell us the specific restriction requested and to whom you want the restriction to apply.

You have the right to receive an accounting of disclosures we have made of your protected health information. This essentially means you may receive a listing of certain uses or disclosures made for other than treatment, payment or business operations, and which you have not received or authorized, such as where we have shared information for public health purposes.

You may ask us to amend your record. While we cannot erase your record, we will add your written statement to your protected health information to correct or clarify the record. Your provider may submit a response to the new correction, which will be provided to you.

Breach Notification. We are required to have safeguards in place that protect your health information. In the event there is a breach of those protections, we will notify you, government officials, and others, as the law requires.

Complaints. You may make a complaint to the Administrator or Clinical Director at the IBH office where you receive services or to the office of Civil Rights at the Department of Health and Human Services if you believe your privacy rights have been violated by us.