



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, chat, data communications.

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.at,
- (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 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 will 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.
- (4) In addition, I understand that telemental -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.
- (5) I understand that I may benefit from telemental health, but that results cannot be guaranteed or assured.
- (6) 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.
- (7) 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.
- (8) 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.

Administrative Support Presence During Telehealth Sessions Authorization

I acknowledge and understand that, for operational, administrative, and technical support purposes, an authorized member of the IBH administrative staff may be present during telehealth therapy sessions, including ongoing and recurring appointments.

The administrative staff member's role is strictly limited to non-clinical functions, including patient intake coordination, identity verification, scheduling assistance, technical troubleshooting, reconnection support in the event of interrupted service, and other administrative matters necessary to facilitate the delivery of telehealth services.

The administrative staff member is not a therapist, counselor, physician, nurse practitioner, or other clinical provider, and will not provide treatment, participate in psychotherapy, interpret clinical information, or make clinical decisions. Unless assistance is required, the administrative staff member will remain silent and may keep their camera and microphone disabled.

I understand that all authorized personnel with access to my sessions are bound by confidentiality, privacy, and data protection obligations in accordance with applicable federal and state laws, including HIPAA where applicable, as well as IBH internal privacy policies.

I understand that I may request clarification regarding the presence of any staff member and may raise concerns regarding privacy accommodations at any time. By signing below, I voluntarily consent to the limited presence of authorized administrative personnel during telehealth sessions under the conditions described above.

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

TELEHEALTH INFORMED CONSENT

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. At Inspirational Behavioral Healing (IBH), teletherapy sessions are most commonly conducted by video call. Depending on patient preference and clinical needs, sessions may also be provided by phone call or chat.

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 at the end of the document, you are acknowledging that you agree to participate in telehealth services.

Medication Management Referral and Continuity of Therapy Requirement

At the Patient's request, if the Patient communicates an interest in receiving medication management services, the Clinic may, through its active professional arrangements, refer or connect the Patient with a Psychiatric Mental Health Nurse Practitioner (PMHNP) for psychiatric evaluation and medication management services.

As part of coordinated care, and unless clinically waived by the treating professionals based on professional judgment, the Patient understands and agrees that ongoing participation in therapy services is generally required in order to access and continue coordinated medication management services through the Clinic's network. This requirement is intended to promote continuity of care, ongoing monitoring of the Patient's mental health status, treatment progress, symptom changes, safety concerns, and coordination of care in alignment with the medication management plan established by the PMHNP.

The Patient acknowledges that medication treatment alone may not be clinically sufficient in many cases and that continued therapeutic follow-up may be recommended in the interest of patient safety and effective treatment outcomes.

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.

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 C 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 different modalities, when the therapist must provide services outside the office area or outside the State (we have service availability in all States and jurisdictions), the service will be considered private.

- The cost of the first session will be USD 180 per hour, and each subsequent session will be USD 150 per hour.
- The client will be responsible for covering the costs of travel and mobilization of the professional to the area of preference.
- Time away from the visitation line will be calculated according to the session cost, prorated by fractions of an hour within working hours:
 - USD 45 per 15 minutes after the first hour (first session).
 - USD 37.50 per 15 minutes after the first hour (subsequent sessions).
- Expert consultations will be charged at:
 - USD 315 per hour or fraction thereof (first session).
 - USD 262.50 per hour or fraction thereof (subsequent sessions).
- If interventions are required outside regular working hours or on Sundays, the session cost will be:
 - USD 270 per hour (first session).
 - USD 225 per hour (subsequent sessions). Additional time will be charged at:
 - USD 67.50 per 15 minutes (first session).
 - USD 56.25 per 15 minutes (subsequent sessions).

In all cases, payment must be made at least 24 hours prior to the scheduled session.

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 C 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.

FINANCIAL POLICY

We, the staff at Inspirational Behavioral Healing C 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 made with debit cards, credit cards, or other electronic methods.
- The private pay rate is USD 180 per hour for the first session and USD 150 per hour for each subsequent session.

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.

In all cases, payment must be made at least 24 hours prior to the scheduled session.

Cancellation Policy “Attendance” and Missed Appointment Private Pay.



The patient is responsible for attending the scheduled appointment, as that time slot has been reserved exclusively for their care. Payment for the session must be made at least 24 hours prior to the appointment.

If the patient cancels the appointment with at least 24 hours' notice, only 50% of the session fee will be refundable. If the cancellation is made with less than 24 hours' notice, or if the patient does not attend the appointment, it will be considered a no-show. In such cases, the patient acknowledges that no refunds will be issued, and the clinic will retain the full amount of the session.

Fees may be waived at the provider's discretion in cases of emergency, hospitalization, or acute mental health crisis. The late cancellation and no-show non-refund policy described herein applies exclusively to patients receiving services on a private pay basis. This policy does not apply to patients whose services are covered, in whole or in part, by any form of health insurance, including private insurance plans, Medicare, or Medicaid.

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.

GENERAL OFFICE POLICY

Appointments and Confirmation calls:

- It is the clients' responsibility to keep their appointments or cancel them within 24 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 might charge for all missed late, or canceled appointments that are not canceled within the 24 -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:

I acknowledge that, should I request a copy of my clinical record, I must notify the Clinic in advance, pay a fee of Fifty Dollars (USD \$50.00). and provide my complete mailing address for the document to be sent with return receipt. I understand that, if the volume or weight of the requested clinical record results in a package whose dimensions exceed ordinary postal parameters, any additional costs applicable under the current postal service rates will be my responsibility. I understand that the preparation of the copy of my clinical record may take between five (5) and seven (7) business days.

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 that 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

The patient is responsible for attending the scheduled appointment, as that time slot has been reserved exclusively for



their care. Payment for the session must be made at least 24 hours prior to the appointment.

If the patient cancels the appointment with at least 24 hours' notice, only 50% of the session fee will be refundable. If the cancellation is made with less than 24 hours' notice, or if the patient does not attend the appointment, it will be considered a no-show. In such cases, the patient acknowledges that no refunds will be issued, and the clinic will retain the full amount of the session fee.

The late cancellation and no-show non-refund policy described herein applies exclusively to patients receiving services on a private pay basis. This policy does not apply to patients whose services are covered, in whole or in part, by any form of health insurance, including private insurance plans, Medicare, or Medicaid.

Repeated Cancellations and No-Show Policy for Insured Patients

For patients whose services are covered by health insurance, including private insurance plans, Medicare, or Medicaid, the Clinic does not impose monetary charges for late cancellations or no-show appointments.

However, if a patient incurs three (3) cancellations without valid justification or three (3) no-show appointments, whether consecutive or non-consecutive, the Clinic reserves the right to discontinue services and to decline scheduling future appointments, due to repeated noncompliance that materially interferes with the continuity of care and the effective operation of the clinical practice.

This policy is applied in a reasonable, uniform, and non-discriminatory manner and is intended to protect the integrity of clinical services, the appropriate allocation of clinical resources, and access to care for other patients.

If a client has been closed due to repeated cancellations, 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.

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 of 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.

I certify with my signature that I have read this document in its entirety, that I fully understand the information



presented, and that I voluntarily consent to participate in teletherapy/telepsychology sessions. I fully understand the entirety of this consent. I have not been coerced into signing, and I am in full possession of the freedom and capacity to comprehend everything that has been explained to me in this document.

Client Patient (Legal Guardian)

IBH

Date

Date

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# _____

Section 3 -CURRENT MEDICATIONS s 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

Section 4 - DEPENDENCE ILLICIT SUBSTANCE ABUSE HISTORY:

Do you smoke? Yes No If yes, how many packs a day C 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: _____

**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).

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)

- | | |
|---|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> HIV/AIDS relation information |
| <input type="checkbox"/> Mental Health Information | <input type="checkbox"/> Referrals |
| <input type="checkbox"/> Drug/Alcohol related information | <input type="checkbox"/> Initial Assessment |
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> IAP "Treatment plan" | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Discharge Summary | |

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)*

- | | |
|---|--|
| <input type="checkbox"/> Assess for intake purposes | <input type="checkbox"/> Coordinate Care |
| <input type="checkbox"/> Provide Treatment | <input type="checkbox"/> Review for Services |
| <input type="checkbox"/> Review History | <input type="checkbox"/> Other (specify): |

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 months? 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Follow diet? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Medications affecting nutritional status? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Change in appetite? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight gain/loss of 10 pounds? | <input type="checkbox"/> Yes <input type="checkbox"/> 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 provider

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: _____ State: _____
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:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Evaluations | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Admission Documentation
Notes | <input type="checkbox"/> Transfer Summary | <input type="checkbox"/> Assessments & Tests | <input type="checkbox"/> Psychotherapy |
| <input type="checkbox"/> ISPs & IAPs | <input type="checkbox"/> Physical Exam | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Psychiatry Notes |
| <input type="checkbox"/> Neuropsychic Testing
below) | <input type="checkbox"/> Consultations (Include name of consultant) | | <input type="checkbox"/> Other (specify |

Purpose for the authorization (must check one):

- The subject of the information or Personal Representative initiated the authorization (specific purpose not required) Or
- | | |
|--|--|
| <input type="checkbox"/> Coordinate care | <input type="checkbox"/> Facilitate billing |
| <input type="checkbox"/> Referral | <input type="checkbox"/> Obtain Insurance, financial or other benefits |

Other purpose (please specify):

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.



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.

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

**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 will 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.

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: _____

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.

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

Client signature: _____ Date: _____

Parent/Guardian name: _____ Relationship: _____

Date: _____