**Patient Name (Printed): ____________________________________**
**DOB (mm/dd/year): ____/____/_____**

## PATIENT ACKNOWLEDGEMENT AND INFORMED CONSENT FOR TREATMENT

On behalf of myself, or the patient named herein, if applicable, I acknowledge that I understand and hereby consent to all the statements made in this form. Changes or alterations to this form are not binding on PSYCH360 and/or its affiliated facilities (each and all of them referred to as "PSYCH360" in this form).

## INFORMED CONSENT TO HEALTH CARE SERVICES

I am hereby requesting that health care services be provided to me (or the patient named below) by PSYCH360. I voluntarily consent to all medical treatment and health care-related services that the personnel of PSYCH360 considers to be necessary for me or the patient named herein. These services may include examinations, diagnostic, therapeutic or imaging procedures, psychotherapy, psychiatric services, counseling services, the administration of drugs orally or by injection, the retrieval of specimens, and laboratory services, including potentially HIV testing. If I want any HIV testing to be performed anonymously, I will tell my PSYCH360 caregiver. My blood may be used to perform routine quality assurance testing. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

I understand and agree that PSYCH360 may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

## ASSIGNMENT OF INSURANCE BENEFITS/THIRD-PARTY PAYERS

In consideration of all health care services rendered or about to be rendered to me (or the named patient), I hereby assign to PSYCH360 all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding PSYCH360's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by PSYCH360 to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third party payer.

## FINANCIAL RESPONSIBILITY

Subject to applicable law and the terms and conditions of any applicable contract between PSYCH360 and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the named patient), I agree to be financially responsible and obligated to pay PSYCH360 for any balance not paid by my health care insurance under the "Assignment of Insurance Benefits/ Third Party Payers" paragraph above. I also agree to pay for any expense incurred by PSYCH360 in collecting the amounts I have agreed to pay, including all court costs, reasonable attorney's fees and all other collection expenses.

## USES AND DISCLOSURES OF HEALTH INFORMATION

I have received PSYCH360's Notice of Privacy Practices. The Notice of Privacy Practices explains how PSYCH360 may use and disclose confidential health information that identifies me (or the named patient). I consent to let PSYCH360 use and disclose health information about me (or the named patient) as described in the Notice of Privacy Practices. In doing so, I consent to the release of my (or the named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by PSYCH360, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent PSYCH360 or provide assistance to PSYCH360 for the purposes of securing payment from all parties who are potentially liable for payment for my (or the named patient's) health care, including for substance abuse, psychiatric care, psychology care, counseling or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that PSYCH360 has already relied on my consent.

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to PSYCH360 on this form or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from PSYCH360 and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from PSYCH360 or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

I hereby consent and grant to PSYCH360 the right and authority to photograph and/or record me, my image and voice, which could occur in connection with my diagnosis and treatment, and I agree that upon creation such images and/or recordings are owned by PSYCH360. I understand that I have the right to request cessation of recording or filming at any time. I agree to release and forever discharge PSYCH360, its agents, officers, employees and subcontractors from any and all claims arising out of or in connection with the use of these images and/or recordings including, but not limited to, any claims for invasion of privacy, right to publicity or defamation.

**By signing below, I am indicating that I have reviewed, understand, acknowledge and consent to the terms described above.**

***COMPLETE SECTION (1) OR (2) NOT BOTH.***

REQUIRED

REQUIRED

REQUIRED

| **(1) CONSENT** | |
|---|---|
| **Signature of Patient or Legal Representative**<br><br>X ____________________ | **Date and Time**<br><br>____________________ |
| **Printed Name of Patient**<br>____________________ | **Relationship of Legal Representative to Patient** (parent, legal guardian, relative or other person who arranges patient's treatment of manages patient's affairs, relative or other person who receives Government benefits on patient's behalf)<br>____________________ |
| **Printed Name of Legal Representative, if applicable**<br><br>____________________ | |

| **Phone Numbers/Email of Patient** | **Phone Numbers/Email Address of Legal Representative, if applicable** |
|---|---|

| REQUIRED | | |
|---|---|---|
| REQUIRED | **Home:** (____) ______ - ___________<br>**Cellular:** (____) ______ - ___________<br>**Email:** ____________________________ | **Home:** (____) ______ - ___________<br>**Cellular:** (____) ______ - ___________<br>**Email:** ____________________________ |
| REQUIRED<br>REQUIRED | **Witness Signature:**<br>**X** ________________________________________<br>**Printed name of Witness:**<br>__________________________________________ | **Date and Time:**<br>__________________________________________ |

| | (2) TELEPHONE CONSENT | |
|---|---|---|
| REQUIRED | **Printed Name of Individual Providing Telephone Consent**<br>__________________________________________ | **Date and Time**<br>__________________________________________ |
| REQUIRED | **Printed Name of Patient**<br>__________________________________________ | **Relationship of Legal Representative to Patient** (parent, legal guardian, relative or other person who arranges patient's treatment of manages patient's affairs, relative or other person who receives Government benefits on patient's behalf)<br>__________________________________________ |
| REQUIRED | **Printed Name of Legal Representative, if applicable**<br>__________________________________________ | |
| REQUIRED | **Phone Numbers/Email of Patient**<br>**Home:** (____) ______ - ___________<br>**Cellular:** (____) ______ - ___________<br>**Email:** ____________________________ | **Phone Numbers/Email Address of Legal Representative, if applicable**<br>**Home:** (____) ______ - ___________<br>**Cellular:** (____) ______ - ___________<br>**Email:** ____________________________ |
| REQUIRED<br>REQUIRED | **Witness Signature:**<br>**X** ________________________________________<br>**Printed name of Witness:**<br>__________________________________________ | **Date and Time:**<br>__________________________________________ |

# PSYCH360 – NOTICE OF PRIVACY PRACTICES (revised 11-11-2020)

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

The privacy practices described in this Notice (as defined below) will be followed by healthcare professionals, employees, medical staff, trainees, students, contracted service providers, and volunteers in the clinically integrated healthcare setting of PSYCH360 ("PSYCH360" or "we"). At the end of this Notice is a list of the providers and locations to which this Notice of Privacy Practices applies.

Doctors and other caregivers who are not employed by PSYCH360 exchange information about you as a patient with other providers such as PSYCH360 and its employees or contractors. These healthcare practitioners may also give you other privacy notices that describe their office practices.

All of these hospitals, doctors, healthcare providers, entities, facilities, associates and services (including PSYCH360) may share your health information with each other for reasons of treatment, payment, and healthcare operations as discussed below.

PSYCH360 is required by law to maintain the privacy of its patients' personal, protected health information, to provide patients with notice of our legal duties and privacy practices with respect to personal, protected health information, and to notify you following a breach of any unsecured protected health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all personal, protected health information maintained by us. You may receive a copy of any revised Notice by emailing a request to **info@Psych360.org**. Contact information is provided below. This Notice is also posted on our website.

## USES AND DISCLOSURES OF YOUR PERSONAL PROTECTED HEALTH INFORMATION

**Your Authorization**. Except as outlined below, we will not use or disclose your personal, protected health information for any purpose unless you have signed a form authorizing the use or disclosure of such information. You have the right to revoke such authorization in writing except in regard to any action we have taken in reliance upon a prior authorization.

**Uses and Disclosures for Treatment**. We use and disclose your personal, protected health information as necessary for your treatment. For instance, doctors, nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, etc. We may also release your personal, protected health information to another healthcare facility or professional who is not affiliated with our organization but who is or will be providing treatment to you. For instance, if, after you leave a nursing facility, you are going to receive home healthcare, we may release your personal, protected health information to that home healthcare agency so that a plan of care can be prepared for you. However, the use and disclosure of psychotherapy notes under certain circumstances may

require an additional authorization in writing which may also be revoked by you in writing, except to the extent that information has been relied upon. PSYCH360 and related offices make electronic medical record information and results available through electronic health systems to PSYCH360 related and affiliated providers as well as unrelated healthcare providers who agree to access the information for the purpose of patient care and treatment.

**Uses and Disclosures for Payment**. We will use and disclose your personal, protected health information as necessary for the payment purposes of those health professionals and facilities that have treated you or provided services to you. For instance, we and the health professionals involved in your care may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

**Uses and Disclosures for Healthcare Operations**. We will use and disclose your personal, protected health information as necessary and as permitted by law, for our healthcare operations that include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal, protected health information for purposes of improving the clinical treatment and care of our patients. We may disclose protected health information to doctors, nurses, technicians, medical students, volunteers and other persons for review and learning purposes and for the operation of educational programs. We may also disclose your personal, protected health information to another healthcare facility, healthcare professional, or health plan for such things as compliance, billing audits, quality assurance and case management, if that facility, professional, or plan also has or had a patient relationship with you or is part of the clinically integrated healthcare setting.

**Family and Friends Involved in Your Care**. Upon your designated authorization(s), we may disclose your personal, 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, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal, protected health information as necessary with such individuals without your approval. We may also disclose limited personal, 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 components of our services are performed through contracts with outside persons or organization such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide some of your personal, protected health information to one or more of these outside persons or organizations who assist us with our healthcare operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

**Fundraising**. We may contact you to donate to a fundraising effort for or on behalf of our non-profit entities. You have the right to "opt-out" of receiving fundraising materials or communications and may do so by emailing **info@Psych360.org**. Other or updated information regarding your opt-out rights may be included in fundraising or educational materials.

**Appointments and Services.** We may contact you with appointment reminders or information

about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to receive confidential communications regarding your protected health information. You have the right to request to receive communications regarding your personal, protected health information by alternative means or at alternative locations and we will try to accommodate such requests if reasonable. For instance, you may not want appointment reminders left on voice mail or sent to a particular address and we will accommodate reasonable requests. You may request such confidential communication in writing and may send your request to info@Psych360.org.

**Health Products and Services.** We may from time to time use your personal, protected health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services we offer, and to provide general health and wellness information.

**Marketing and Sale of Information**. We do not market or sell your personal protected health information. We will not engage in subsidized communications about health related products or services, with the exception of face-to-face communication or promotional items of minimal value, without your authorization. You may revoke any such authorizations in writing at any time.

**Research.** With your consent, or in limited circumstances, we may use and disclose your personal, protected health information for research purposes. For example, a researcher may wish to compare outcomes of all patients that received a particular drug and will need to review a series of medical records. In all cases where your authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board that oversees the research, or by representations of the researchers that limit their use and disclosure of patient information.

**Other Uses and Disclosures.** We are permitted or required by law to make certain other uses and disclosures of your personal, protected health information without your authorization. We may release your personal, protected health information:

- for any purpose required by law;
- for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- as required by law if we suspect child abuse or neglect or if we believe you to be a victim of abuse, neglect, or domestic violence;
- to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- to your employer when we have provided healthcare to you at the request of your employer; in most cases you will receive notice that information is disclosed to your employer;
- if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- if required to do so by court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;
- to law enforcement officials as required by law to report wounds and injuries and crimes;
- 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 as required by armed forces services; we may also release your personal, protected heath information if necessary for national security or intelligence activities; or

● to workers' compensation agencies if necessary for your workers' compensation benefit determination.

## YOUR RIGHTS

**Access to Your Personal, Protected Health Information**. You have the right to receive a copy and/or inspect most of the personal, protected health information that we retain on your behalf. Certain information is subject to additional protections and authorizations as required by law (e.g., psychotherapy notes). All requests for access must be made in writing and signed by you or your legal representative. We may charge you a reasonable fee if you request a copy of the information. We may also charge for postage if you request a mailed copy.

**Authorization for Release of Information.** You have the right to electronic copies of your health information when it is stored in electronic format. Patients or their legal representatives may request access to their personal, protected health information by completing the Authorization for Release of Medical Information form.

**Amendments to Your Personal, Protected Health Information.** You have the right to request in writing that personal, protected health information we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If we make an amendment or correction that you request, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary.

**Accounting for Disclosures of Your Personal, Protected Health Information.** You have the right to receive an accounting of certain disclosures made by us of your personal, protected health information. Requests must be made in writing and signed by you or your legal representative. The first accounting in any 12-month period is free; you will be charged a reasonable fee for each subsequent accounting you request within the same 12-month period.

**Restrictions on Use and Disclosure of Your Personal, Protected Health Information.** You have the right to request restrictions on certain uses and disclosures of your personal, protected health information for treatment, payment, or healthcare operations. Subject to certain exceptions,[1] we are not required to agree to your restriction requests but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Privacy Officer. You may ask a

[1] For example, 45 CFR § 164.522(a)(1)(vi): A covered entity must agree to the request of an individual to restrict disclosure of protected health information about the individual to a health plan if: (A) The disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (B) The protected health information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

provider to restrict certain disclosures of protected health information to a health plan or insurance company, for purposes of payment or healthcare operations, if you have paid that provider in full for the healthcare item or service, out of pocket.

**Complaints.** If you believe your privacy rights have been violated, you can file a complaint at **info@psych360.org**. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. in writing within 180 days of a perceived violation of your rights. There will be no retaliation for filing a complaint.

**U.S. Department of Health and Human Services**
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

EFFECTIVE July 1, 2015, UPDATED**:** 1/8/19

**Notice of Breach.** You will receive notification if there has been an impermissible use or disclosure resulting in the compromise of your protected health information.

**PROVIDERS AND LOCATIONS**

This Notice applies to all locations where PSYCH360 provides treatment, including, but not limited to, all PSYCH360 facilities and all long-term care facilities under contract with PSYCH360.

The professionals and entities comprising an "Organized Healthcare Arrangement" and sharing information for treatment, payment and healthcare operations include, but are not limited to: PSYCH360 healthcare professionals, whether employed or independent, as they provide services for or on behalf of PSYCH360.

**FOR MORE INFORMATION**

If you have any questions or need further assistance regarding this Notice, you may contact the **info@psych360.org**.