Cancellation Policy

A cancelled appointment hurts three people: you, your provider, and another client who could have potentially used your time slot. Therapy sessions are scheduled in advance and are a time reserved exclusively for you. We reserve for you a full hour of our time for the session and clinical notes. If a client cancels with less than 2 days notice, it is unlikely that we will be able to fill that time slot, and we lose an entire hour from our work schedule.

When a session is cancelled without adequate notice, we are unable to fill this time slot by offering it to another current client, a client on the wait list, or a client with a clinical emergency. Without a cancellation fee policy in place, your provider will lose money or the opportunity to schedule another client if you late cancel or do not show up.

Our cancellation policy is this: Clients can cancel or reschedule an appointment anytime if they provide **up to 2 days notice**. If you cancel an appointment with less than **2 days notice, you will be charged 50% of the appointment fee. If you fail** to show up on the day of appointment, you will be charged **100% of the appointment fee.**

This cancellation policy is not a penalty or a punishment. Most clients understand this. Very rarely, there will be a client who will feel that he or she is being punished when they are charged a late cancellation fee. We want to make sure that you don't feel this way, if someday you miss an appointment.

It is likely, if you are in counseling long enough, at some point you might forget about an appointment, or something will come up in your schedule that will result in you missing an appointment. Maybe you'll need to work late, or your car will break down, or something unavoidable will come up. Therefore we ask that you communicate with us as soon as possible to reschedule your appointment.

Also, if you are more than 15 minutes late to your appointment time, it will be treated like a late cancellation.

Your **FULL FEE** will be charged when you miss or cancel an appointment without giving **at least 2 days notice**. This means that if an appointment is scheduled for 3:00 pm on a Wednesday, notice must be given by 3:00 pm on Monday at the latest.

While it is a time commitment, this is for your personal growth and consistency is key in order to achieve this.

CONSENT FOR TREATMENT

I hereby authorize **CONVENIENTPSYCHMD, PLLC** to provide treatment and/or psychotherapy as explained to me. I understand that while this therapy may be beneficial, as with any treatment, there are inherent risks. During treatment, I will discuss personal issues which may bring up uncomfortable emotions such as anger, guilt, and sadness. The benefits of treatment can far outweigh this discomfort and can lead to benefits such as improved personal relationships and reduced feelings of emotional distress. I acknowledge, however, that no warranty or guarantee can be made as to the results of therapy.

CONFIDENTIALITY: I understand that discussions between myself and my therapist/provider as well as any records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to me. No information will be released without my written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following: abuse of any other person, sexual exploitation, AIDS/HIV infection and possible transmission, criminal prosecutions, child custody cases, suits in which the mental health of a party is in issue, situations where the therapist/provider has a duty to disclose, or where, in the provider/therapist's judgment, it is necessary to warn or disclose, a negligence suit brought by the client against the provider/therapist, or the filing of a complaint with the licensing or certifying board. If I have any questions regarding confidentiality, I will bring them to the attention of my provider/ therapist. By signing this Information and Consent Form, I am giving consent to the undersigned provider/ therapist to share confidential information with all persons mandated by law and with the agency that referred me and the insurance carrier responsible for providing my mental health care services and payment for those services. I am also releasing and holding harmless the undersigned provider/therapist from any departure from my right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my provider/therapist believes that I am in physical or emotional danger or I am a danger to another human being, I understand that my therapist is required by law to contact medical or law enforcement personnel to prevent harm to me or another person, and may contact the person in danger.

CONSENT TO TREATMENT: Treatment and/or psychotherapy as stated, including the possible risks, complications, options, and expectations have been explained to me or my representative and consent for treatment is thus given as noted by signature. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me, and I understand that I may stop such treatment or services at any time.

Payment Policies

Please read and completely fill out the form below.

Before your first scheduled session, you are required to have a valid credit card on file. For private pay clients and for any co-pays, co-insurances or deductibles that are not captured by a separate service, I utilize my electronic health record system (IntakeQ) that is HIPAA and PCI Compliant. There is a form below to capture your CC information.

- By completing and signing this Payment Agreement, you are indicating that you understand and agree to provide a valid credit card number, with expiration date, for payment of future therapy sessions, appointments or other fees.
- Your signature indicates you understand that if you do not attend a scheduled appointment your credit card will be charged the regular session fee unless you cancelled your appointment **at least 2 days in advance**, for cancellations with less than 2 days, 50 % of the fee will be charged. For missed appointments with no notice given, 100% will be charged.
- Your credit card number will be kept on file throughout treatment and will be charged on the day of appointment**.** It is expected that your session be paid for by or at the time of service, unless other arrangements have been made. I reserve the right to cancel a session if payment is not made.
- Your signature indicates that you may be charged for other services such as, extended phone calls, consultation on your behalf, and other services rendered on your behalf.
    - ***EXAMPLES:*** Other professional services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. All these services are charged at a prorated rate of $100/hour in 15 minute increments. (increment of 15 minutes after 60 minutes guaranteed for your initial appointment)

    - If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. [I charge $400 per hour for professional services I am asked or required to perform in relation to your legal matter].
- Your signature indicates that you are an authorized card user for the card you are placing on file.
- If you are using your insurance for receiving therapy, you will be asked to fill out a separate authorization to bill insurance. It is your responsibility to know your benefits and to pay for your sessions.
    - If a session is not covered due to lapse of benefits or change in carrier, and you do not notify me of this change, you will be charged my current full fee. Please review the insurance payment form for more information.
- If you are paying out-of-pocket, or using "out of network benefits" you will be charged the same fees.

I understand that a re-billing fee/financial charge complying with your State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. A copy of this agreement will be available in your client portal.

*** Rates for primary care visits are different. Please note.

Urgent cares are typically about 20 min visits - $100.00

Primary care virtual visits which are typically 45-60 min - $ 200.00

FOR CASH ONLY CLIENTS WITHOUT INSURANCE SEEKING MENTAL HEALTH SERVICES.

60 Min psychiatric evaluations - $ 395.00

45 min Post hospital discharge follow up - $325.00

30 min medication management $ 200.00

HIPAA & Notice of Privacy Practices

CONVENIENTPSYCHMD, PLLC is committed to maintaining and protecting the confidentiality of the individual's PHI. **CONVENIENTPSYCHMD, PLLC** is required by federal and state law, including the Health Insurance Portability and Accountability Act ("HIPAA"), to protect the individual's PHI and other personal information. CONVENIENTPSYCHMD, PLLC is required to provide the individual with this Notice of Privacy Practices regarding their specific policies, safeguards, and practices. When **CONVENIENTPSYCHMD, PLLC** uses or discloses an individual's PHI, **CONVENIENTPSYCHMD, PLLC** is bound by the terms of this Notice of Privacy Practices, or the revised notice of Privacy Practices, if applicable.

I. My Pledge Regarding Your Personal Health Information:

- I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:
    - Make sure that protected health information ("PHI") that identifies you is kept private.
    - Give you this notice of my legal duties and privacy practices with respect to health information.
    - Follow the terms of the notice that is currently in effect.
    - I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. How I May Use and Disclose Your Health Information:

The following describes the ways **CONVENIENTPSYCHMD, PLLC** may use and disclose PHI. Except for the purposes described below, **CONVENIENTPSYCHMD, PLLC** will use and disclose PHI only with the individual's written permission. The individual may revoke such permission at any time by writing to **CONVENIENTPSYCHMD, PLLC**: Compliance Officer

- **For Treatment:** We may use and disclose PHI for the individual's services. For example, CONVENIENTPSYCHMD, PLLC may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside **CONVENIENTPSYCHMD, PLLC**, who are involved in the individual's medical care and need the information to provide the individual with medical care.
- **For Payment:** We may use and disclose PHI so that or others may bill and receive payment from the individual, an insurance company or third party for the treatment and services the individual received. For example, we may tell the individual's insurance company about a treatment the individual is going to receive to determine whether the individual's insurance company will cover the treatment.
- **For Health Care Operations:** We may use and disclose PHI for health care operation purposes. The uses and disclosures are necessary to make sure that all **CONVENIENTPSYCHMD, PLLC** patients receive quality care and to operate and manage our office.
- **Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services:** We may use and disclose PHI to contact the individual to remind them that they have an appointment with **CONVENIENTPSYCHMD, PLLC**. We also may use and disclose PHI to tell the individual about treatment alternatives or health-related benefits and services that may be of interest to the individual.
- **Research:** Under certain circumstances, **CONVENIENTPSYCHMD, PLLC** may use and disclose PHI for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. **CONVENIENTPSYCHMD, PLLC** will generally ask for the individual's written authorization before using the individual's PHI or sharing it with others to conduct research. Under limited circumstances, we may use and disclose PHI for research purposes without the individual's permission.
- **Incidental Use and Disclosure:** We are not required to eliminate every risk of an incidental use or disclosure of your PHI. Specifically, a use or disclosure of your PHI that occurs as a result of, or incident to an otherwise permitted use or disclosure is permitted as long as I have adopted reasonable safeguards to

protect your PHI, and the information being shared was limited to the minimum necessary.

III. Special Situations in Which I May Disclose PHI Without Your Consent:

- **As Required by Law:** We will disclose PHI when required to do so by international, federal, state, or local law.
    - **To Avert a Serious Threat to Health or Safety:** We may use and disclose PHI when necessary to prevent a serious threat to the individual's health and safety or the health and safety of others. Disclosures, however, will be made only to someone who may be able to help prevent or respond to the threat, such a law enforcement or potential victim. For example, we may need to disclose information to law enforcement when a patient reveals participation in a violent crime.
    - **Law Enforcement:** We may release PHI if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, **CONVENIENTPSYCHMD, PLLC** is unable to obtain the individual's agreement; (4) about a death **CONVENIENTPSYCHMD, PLLC** believes may be the result of criminal conduct; (5) about criminal conduct on **CONVENIENTPSYCHMD, PLLC** premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
    - **Abuse or Neglect:** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information we disclose is limited to only that information which is necessary to make the required mandated report.
    - **Essential Government Functions:** We may be required to disclose your PHI for certain essential government functions. Such functions include but are not limited to: assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President, making medical suitability determinations for U.S. State Department employees, protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.
- **Business Associates:** We may disclose PHI to any business associates that perform functions on our behalf or provide **CONVENIENTPSYCHMD, PLLC** with services if the information is necessary for such functions or services. All

of **CONVENIENTPSYCHMD, PLLC** business associates are obligated to protect the privacy of the individual's information and are not allowed to use or disclose any information other than as specified in our contract.

- **Lawsuits and Disputes**: If the individual is involved in a lawsuit or a dispute, **CONVENIENTPSYCHMD, PLLC** may disclose PHI in response to a court or administrative order. **CONVENIENTPSYCHMD, PLLC** also may disclose PHI in response to a subpoena, discovery request, or other lawful request by someone else involved in the request or to allow the individual to obtain an order protecting the information requested.
- **Health Oversight**: I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors) and peer review organizations performing utilization and quality control. If we disclose PHI to a health oversight agency, we will have an agreement in place that requires the agency to safeguard the privacy of your information.
- **Psychotherapy Notes**: If kept as separate records, we must obtain your authorization to use or disclose psychotherapy notes with the following exceptions. We may use the notes for your treatment. We may also use or disclose, without your authorization, the psychotherapy notes for my own training, to defend myself in legal or administrative proceedings initiated by you, as required by the **APPLICABLE STATE AGENCY** or the US Department of Health and Human Services to investigate or determine my compliance with applicable regulations, to avert a serious and imminent threat to public health or safety, to a health oversight agency for lawful oversight, for the lawful activities of a coroner or medical examiner or as otherwise required by law.

IV. You Have the Following Rights with Respect to Your PHI:

- **The Right to Request Limits on Uses and Disclosures of Your PHI**: You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
- **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full:** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

- **The Right to Choose How I Send PHI to You**: You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
- **The Right to See and Get Copies of Your PHI:** Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 2- 4 WEEKS of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.
- **The Right to Get a List of the Disclosures I Have Made:** You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within **2 - 4 WEEKS** of receiving your request. The list I will give you will include disclosures made in **APPLICABLE TIME FRAME (CHECK STATE/FEDERAL LAWS)** unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.
- **The Right to Correct or Update Your PHI:** If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within **2 - 4 WEEKS.**
- **The Right to Get a Paper or Electronic Copy of this Notice:** You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it. (This notice will be available in your client portal).
- **Right to Get Notice of a Breach: CONVENIENTPSYCHMD, PLLC** is committed to safeguarding the individual's PHI. We utilize a safe and effective electronic medical record provided through our partnership with IntakeQ. If a breach of the individual's PHI occurs **CONVENIENTPSYCHMD, PLLC** will notify the individual in accordance with state and federal law.
- **Right to Request Restrictions:** Individuals have the right to request a restriction or limitation on the PHI **CONVENIENTPSYCHMD, PLLC** uses or disclose for treatment, payment, or health care operations. Individuals also have the right to request a limit on the PHI we disclose to someone involved in the individual's care or the payment for the individual's care, like a family member or friend.
    - To request a restriction, the individual must make their request, in writing, to the Department in which their care was

provided. **CONVENIENTPSYCHMD, PLLC** is not required to agree to the individual's request unless the individual is asking us to restrict the use and disclosure of the individual's PHI to a health plan for payment or health care operation purposes and such information the individual wishes to restrict pertains solely to a health care item or service for which the individual has paid Mindful Way Out-of-pocket in full. If we agree, we will comply with the individual's request unless the information is needed to provide the individual with emergency treatment or to comply with law. If we do not agree, we will provide an explanation in writing.

- **Out-of-Pocket Payments:** If the individual pays out-of-pocket (or in other words, the individual has requested that **CONVENIENTPSYCHMD, PLLC** not bill the individual's health plan) in full for a specific item or service, the individual has the right to ask that the individual's PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Acknowledgment of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

STATES WE ARE LICENSED IN PRIMARY CARE SERVICES

Montana	Wyoming
Mnnesota	Idaho
Nevavada	Michigan
Wisonsin	Washington State
Utah	Nebraska

STATES WE ARE LICENSED IN FOR PSYCIATRY

Texas	Wisconsin
Minnesota	North Dakota
Oklahoma	Kansas