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MEDICATION TREATMENT INFORMED CONSENT

Welcome to Willow Tree Wellness, LLC. Since this is your first visit, we hope what is written here can answer some of your questions as you seek Medication Management. Please ask if you need clarification on any of the topics discussed in this Medication Treatment Informed Consent. Also, ask if you have questions that are not addressed in this contract. When you sign this document, you are stating that you understand and will adhere to the information in this Medication Treatment Informed Consent.

MEDICATION SERVICES

When you receive psychotropic medication, you will receive information describing the following:

- The specific condition to be treated;
    - The beneficial effects on that condition expected from the medication;
    - The possible health and mental health consequences of not consenting to the medication;
    - The probable clinically significant side effects and risks associated with the medication; and
    - The generally accepted alternative medications and non-pharmacological interventions to the medication, if any, and the reason for the proposed course of treatment.
- I have been given the opportunity to ask questions.
- This consent is given voluntarily and without undue influence.
- I understand that I have a right to withdraw the consent for this treatment at any time, after consulting with the prescribing provider.

AVAILABILITY BETWEEN SESSIONS

If needed, you can leave your medication provider a message on their office line located on the back of their business card. When you leave a message, include your telephone number even if you think we already have it. Please let us know the best times to reach you. We make every effort to return calls in a timely manner. If you do not hear back from us within one business day, please leave a second message.

If you are in an emergency situation and cannot wait for us to return your call, go to the nearest emergency room or call 911. Additional help is available by dialing 988. Willow Tree Wellness, LLC is not a crisis facility. Do not contact us by email or fax in an emergency, as we may not get the information quickly.

RATES AND INSURANCE

Seeking medication management is a commitment of time, energy and financial resources. If you have health insurance, it is important for you to verify your mental health benefits, so you understand your coverage prior to your appointment. Some insurance companies require a precertification before the first appointment, or they will not cover the cost of services.

Our current fees are as follows:

- Initial Medication Intake Appointment: $240.00
- 15 min Medication Management appointment: $125.00
- 30-minute Medication Management appointment: $150.00
- Patients with insurance: the negotiated rate with each insurance company
- There are CPT Codes and procedures not listed, please ask your provider for more information.

We also provide telephone and/or telehealth sessions in certain circumstances. Some health insurance carriers cover telehealth (telephone/online medication management). If your insurance plan does not cover telehealth, it is your responsibility to pay our full rate per session if you opt for telehealth sessions. ***First time appointments are not available for telehealth sessions. Your provider must approve telehealth sessions in advance.***

We are happy to assist you by having our staff file claims to your insurance company on your behalf. However, you are responsible for payment of the fee for service, not your insurance company. Acceptable forms of payment include cash, check and major credit cards. Payment is expected at the time of service. **Cancellations or missed appointments without 24 hours notice will be subject to a $50 cancellation fee. Insurance companies do not pay charges for missed appointments.** If fees for services are not paid in a reasonable amount of time and attempts have been made to resolve the financial matter to no avail, a client's services could be terminated.

We check your insurance benefits as a courtesy for our clients. There are times when insurance misquotes your benefits. In the event of a misquote, clients are still responsible for your copay/coinsurance/deductible amount that insurance reports after claims are submitted. You can call your insurance company to check your own benefits by calling the number on the back of your insurance card.

Most insurances require you to authorize us to provide a clinical diagnosis and sometimes additional clinical information. This information will become part of the insurance company's files. Insurance companies claim to keep information confidential, but you should check with your insurance company directly if you have questions about their confidentiality practices

SOCIAL MEDIA POLICY

In order to maintain your confidentiality and our respective privacy, we do not interact with current or former clients on social networking websites. We do not accept friend or contact requests from current or former clients on any social networking sites including Twitter, Facebook, LinkedIn, etc. We will not respond to friend requests or messages through these sites.

We will not solicit testimonials, ratings or grades from clients on websites or through any means. We will not respond to testimonials, ratings or grades on websites, whether positive or negative. Our hope is that you will bring concerns about our work together to the session so we can address concerns directly.

Please do not contact us through text messages or emails regarding clinical issues. These are not secure communications. There is a possibility that we will not get the message in a timely manner, or that communication will be interpreted unclearly. If you need to contact your therapist between sessions, please call their office line located on the back of their business card. Text messages and emails are only to be used for scheduling purposes.

PROFESSIONAL RECORDS

Both law and the standards of our professional licensures require we keep appropriate treatment records. If we receive a request for information about you from a 3rd party, you must authorize in writing to release the requested information. This is called a *Release of Confidential Information.*

CONFIDENTIALITY

In general, there are laws that protect the confidentiality of all communication between you and your therapist. We only release information to others with your written permission. More information about your protected health information is provided in your HIPAA statement. However, there are a number of exceptions, which are indicated below.

In judicial proceedings, if a judge orders your records released, we have to release records. We are also ethically and legally required to take action to protect others from harm even if taking this action means we reveal information about you. For example, if we believe a child, elderly person or disabled person is being abused or neglected, we are mandated to report this to the appropriate state agency. If we believe a client is threatening serious harm to another person or property, we must take protective action through notifying the potential victim, the police, and/or facilitating hospitalization. In these situations, we make reasonable effort to discuss any need to disclose confidential information with you. We are happy to answer any questions you have about the exceptions to confidentiality.

COMPLAINTS OR QUESTIONS

If you have a concern or complaint about your treatment or about your billing statement, please talk to us about it. We will take your concerns seriously, openly and respond respectfully.

HIPAA NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and mental health operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. **"Protected health information"** is information about you. This includes demographic information that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing mental health services to you. It is also used to pay your health care bills, to support the operation of this agency's practice and any other use required by law. **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your mental health care and related services. This includes the coordination or management of your mental health care with a third party. For example, we would disclose your protected health information, as necessary, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. **Payment:** Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining authorization for treatment may require that your relevant protected health information be disclosed to the health plan.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include but are not limited to quality assessment and employee review, etc. For example, we may call you by a name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation and Inmates. Under the law, we must also make disclosures to you when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your authorization or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

II. Your Rights

You have the right to inspect and receive a copy of your protected health information. Our practice will accept such requests in writing. Under federal law, however, you may not inspect or receive a copy of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction on the disclosure of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be 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 state the specific restriction requested and to whom you want the restriction to apply. Your therapist is not required to agree to a restriction that you may request. If a therapist believes it is in your best interest to permit use and disclosure of your protected health information, your health information will not be restricted. You then have the right to use another mental health professional.

You have the right to request to receive confidential communications from us by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and may provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made of your protected health information. We reserve the right to change the terms of this notice and will post any changes in our waiting areas. You then have the right to object as provided in this notice.

III. Complaints

You may file any complaints with our office staff, at 316-779- 2560, or with the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. ***We ethically and legally cannot retaliate against you for filing a complaint.***

Medication Treatment Informed Consent Contract

Please ask before signing below if you have any questions about medication management or our office policies. Your signature indicates that you have read our Medication Treatment Informed Consent and agree to enter medication management under these conditions. Your signature below indicates that you are making an informed choice to consent to medication management and understand and accept the terms of this agreement.

I have read and agree to the terms in the Medication Treatment Informed Consent Contract (pages 1-4).

Client Name: ____

Client Signature: ____________________________________Date: __________

Guardian Signature (if minor): __________________________Date: ___________

Guardian Signature (if minor): __________________________Date: ___________

Notice of Privacy Practices

I have read the notice of privacy section (pages 5-6).

Client Name: ____

Client Signature: ___________________________________ Date: __________

Guardian Signature (if minor): _________________________ Date: __________

Guardian Signature (if minor): _________________________ Date: __________