10 E. North Avenue, Suite #5
Baltimore, Maryland 21202
443-282-8146 phone
443-478-4707 fax
restoringdestinymentalhealthservices.org

INFORMED CONSENT FOR MENTAL HEALTH AND TELEMEDICINE SERVICES

MENTAL HEALTH SERVICES

Mental Health Services
Restoring Destiny Mental Health Services recognizes that it may not be easy to seek help from a mental health professional; we hope that with our help you will be better able to understand your situation and feelings and will be able to move toward resolving your difficulties. The therapist will strive to help you grow towards greater health and wholeness by providing counseling services. Our therapists work within the context of each individual's beliefs, and no attempt is made to impose a personal theology.

Therapist
The therapist is a licensed professional engaged in providing mental health care services to clients directly as an employee of RESTORING DESTINY MENTAL HEALTH SERVICES. The therapist has discussed with me the various aspects of psychotherapy. This includes a discussion of the evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. You may withdraw from treatment at any time, but please discuss this with your therapist.

Appointments and Cancellations
Appointments are made by contacting at 443-282-8146, we will meet weekly, bi-weekly or monthly, according to the Client's requirements. If you need to cancel an appointment, please do so at least 24 hours in advance by phone or email. For non-Medicaid patients, failure to cancel within this timeframe may result in a missed appointment fee. There is a 15 minute grace period for all appointments. Please communicate with us regarding delay or cancellation. We are available by text at 443-282-8146 always. Third-party payments will not usually cover or reimburse for missed appointments. Clients who repeatedly miss appointments may be discharged from services. Your therapist reserves the right to cancel your appointment if you show up sick or with minor children that might interfere with the counseling session.

Number and Length of Sessions
The number of sessions needed depends on many factors and will be discussed by the therapist. The length of therapy sessions range depending on several factors, and the therapist will discuss this with you.
However, patients must attend at least 5 therapy sessions before any DSS or SSI or any medical forms of any type can be completed on the patient's behalf. Once a patient/client

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attends 5 therapy sessions, forms can be completed. However, we ask for a 3 week turnaround for completing forms.

Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social and personal relationship with you. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist.

Goals, Purposes, and Techniques of Therapy

There may be multiple interventions to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting goals of your therapy. As therapy progresses, these may change.

Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law or as required by insurance companies for payment. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; 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 has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose; fee disputes between therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with a licensing board or other state or federal regulatory authority.

If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing the Receipt form for the Informed Consent and Privacy Practices, you are giving your consent to the therapist to share confidential information with all persons mandated by law and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services. You are also releasing and holding harmless the therapist from any departure from your right of confidentiality that may result.

Duty to Warn

In the event that the therapist reasonably believes that the client is a danger, physically or emotionally, to themselves or another person, consent is given for the therapist to warn the person in danger and to contact any person in a position to prevent harm to themselves or another person, including law enforcement and medical personnel. This authorization shall expire upon the termination of therapy.

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By signing Informed Consent and Privacy Practices form, you acknowledge that you have the right to revoke this authorization in writing at any time to the extent the therapist has not taken action in reliance on this observation. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the Notice of Privacy Practices section of this form. You acknowledge that you have been advised by the therapist of the potential of the re-disclosure of your protected health information by the authorized recipients, and that it will no longer be protected by the federal Privacy Rule. You further acknowledge that the treatment provided to you by the therapist was conditioned on you providing this authorization.

Risks of Therapy

Therapy is the Greek word for change. Clients often learn things about themselves that they don't like. Often growth cannot occur until past issues are experienced and confronted, often causing distressing feelings such as sadness and anxiety. The success of therapy depends upon the quality of the efforts of both the therapist and client, along with the reality that clients are responsible for the lifestyle choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce option.

Payment for Services

The charge for your one-hour session (_____ minutes with a therapist) is $____ .00. Shorter sessions will be a percentage of the full fee. RESTORING DESTINY MENTAL HEALTH SERVICES will look to you for full payment of your account, and you will be responsible for payment of all charges. If you have insurance, different copayments are required by various group coverage plans. Your copayment is based on the Mental Health Policy selected by your employer or purchased by you. In addition, the copayment may be different for the first visit than for subsequent visits. Clients are responsible for copayments, deductibles, and charges as dictated by their insurance plan. However, as a Medicaid provider, Restoring Destiny Mental Health Services is prohibited from charging Medicaid patients any fees for late cancellations, missed appointments, or copays. You are responsible for notifying RESTORING DESTINY MENTAL HEALTH SERVICES immediately of any changes to your insurance. If you fail to notify RESTORING DESTINY MENTAL HEALTH SERVICES of any changes to insurance, you may be billed for services that are not covered.

Court

Although it is the goal of the therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. In the event disclosure of your records or the therapist's testimony are requested by you or required by law, you will be responsible for and shall pay the costs involved in producing the records.

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Such payments are to be made at the time prior to the time the services are rendered by the therapist. The therapist may require a deposit for anticipated court appearances and preparation.

After-Hour Emergencies
A mental health professional is available on text when RESTORING DESTINY MENTAL HEALTH SERVICES is closed and can be reached for emergencies on a 24-hour, seven-days-per- week basis, by calling 443-282-8146. If you need to contact us after business hours, please give us 24 hours to call you back. In case of any forms that need to be sent to us, our email address is restoringdestinymentalhealth@gmail.com and our fax number is 443-478-4707. Emergencies are urgent issues requiring immediate action.

Therapist's Incapacity or Death
In the event the therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of client records. By signing the Informed Consent and Privacy Practices Receipt, you give your consent to another licensed mental health professional at Restoring Destiny Mental Health Services to take possession of your files and records and provide you with copies upon request, or to deliver them to a therapist of your choice.

Consent to Treatment
By signing the Informed Consent and Privacy Practices Receipt, you voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment, or services at any time. By signing the Informed Consent and Privacy Practices Receipt, you acknowledge that you have both read and understood

all the terms and information contained herein. Ample opportunity has been offered for you to ask questions and seek clarification of anything that remains unclear. Additionally, by signing below, you consent to mental health and telemedicine services, acknowledge that you understand the limitations regarding fees for Medicaid patients, and recognize that you may revoke this consent at any time.

Contact Information
By signing the Informed Consent and Privacy Practices Receipt, you are consenting for RESTORING DESTINY MENTAL HEALTH SERVICES to communicate with you by mail, e- mail, and phone at the address and phone numbers provided at the initial appointment, and you will immediately advise RESTORING DESTINY MENTAL HEALTH SERVICES in the event of any change. You agree to notify the Center if you need to opt out of any form of communication.

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Notice of Authorization for Release of Mental Health Information and Privacy Practices

I authorize **Restoring Destiny Mental Health Services** to use or disclose information from my mental health record, which may include information about psychiatric diagnosis and treatment.

The Privacy notice tells you how we make use of your health information at our Center, how we might disclose your health information to others, and how you can get access to the same information. Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at Restoring Destiny Mental Health Services. These changes could also affect how we protect the privacy of any of your health information we had before the changes. When we make any of these changes, we will also change this notice and give you a copy of the new notice.

When you are finished reading this notice, you may request a copy of it at no charge to you. If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you.

If you have any questions or concerns about the material in this document, please ask us for assistance, which we will provide at no charge to you.

Here are some examples of how we use and disclose information about your health information. We may use or disclose your health information.

1. To your physician or other healthcare provider who is also treating you.

2. To anyone on our staff involved in your treatment program.

3. To any person required by federal, state, or local laws to have lawful access to your treatment program.

4. To receive payment from a third party payer for services we provide for you.

5. To our own staff in connection with our Center's operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff,

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supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.

6. To anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only affect your health information from that point on.

7. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects of your health information that are necessary to respond to the emergency.

8. To the appropriate State agency if, we suspect the neglect or abuse of a minor or adult. If, in our professional judgment, we believe that a patient is threatening serious harm to another, we are required to take protective action, which may include notifying the police, or seeking the client's hospitalization. If a client threatens to harm him or herself, we may be required to seek hospitalization.

We will not use your health information in any of our Center's marketing, development, public relations, or related activities without your written authorization. We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

As a client of the Restoring Destiny Mental Health Services, you have these important rights:

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.

B. You have a right to a copy of this notice at no charge.

C. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if you request that we contact you on an alternative phone number other than your residence, or if your primary language is not spoken at this Center) Your written request must specify the alternative means and location.

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D. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.

E. You can make a written request that we amend the information provided above.

F. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.

G. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.

H. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following details:

Address: 4017 Cranston Avenue, Baltimore, Maryland 21229.
Email: restoringdestinymentalhealth@gmail.com
Fax number: 443-478-4707

Client's Signature

_____ Date _____

Parent/Guardian's Signature

_____ Date _____

(If client is a Minor)

I have discussed and explained the above information with the minor client.

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TELEMEDICINE SERVICES

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include therapists, PRP coordinators, psychiatrists and/or psychiatric nurse practitioners. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. HIPAA compliant software will be used unless permitted otherwise by the state or federal level. As with in-person services, Medicaid patients will not be charged any fees for telemedicine services, including missed appointments.

EXPECTED BENEFITS

Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
More efficient medical evaluation and management.
Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. 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 the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

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BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Restoring Destiny Mental Health Services has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform Restoring Destiny Mental Health Services of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my therapist, PRP coordinator, psychiatrist, psychiatric nurse practitioner or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I understand a copy of this form will be available for me to print.

I hereby authorize Restoring Destiny Mental Health Services to use telemedicine in the course of my diagnosis and treatment.

_____ _____

Client Name Date of Birth

_____ _____

Client/Parent/Guardian Signature Date