

Welcome to Clarity Mental Health, LLC. Your agreement to the following terms and conditions is required for you/your child to receive professional services from me. If you do not agree, I will be glad to give you referrals to other providers.

Clinical services

You consent for yourself/your child to receive a comprehensive diagnostic assessment. At the end of the evaluation, we will mutually decide if we will continue treatment together.

If there is a potential of any physical danger to you, your child, or others, you will call 911 immediately or go to the closest emergency room.

Note I do not have admitting privileges, nor am I affiliated with or on staff at any hospital; however, Northcrest Medical Center has agreed to accept patients under my name if needed, and will be managed accordingly by their hospitalist staff. That being said, it is your choice as a patient to utilize the hospital of your choice should the need arise. Should I deem more intensive services are needed than I can provide, I will do my best to ensure safety and obtain the appropriate level of care, but I cannot provide that care directly and cannot guarantee the receipt or quality of care that others provide.

All communication and clinical treatment will be documented in the patient chart. Both the law and the standards of the profession require such. You are entitled to receive a copy of these records unless I believe that seeing them would be emotionally damaging. If this is the case, I will be happy to provide the records to an appropriate mental health professional of your choice or to prepare an appropriate summary instead. Because client records are professional documents, they can be misinterpreted and can be upsetting. If you wish to see the records, it is best to review them with me so that we can discuss their content.

If you or your child is seeing me for medication management only:

- You will contact your/your child's therapist first for any emergency or crisis, unless it may be medication related.
- You will inform me if you/your child are/am considering stopping therapy, or have actually stopped
- You/your child will see me in person no less than every 3 months for follow-ups.
- If receiving stimulant medication for the treatment of ADD/ADHD your child will be seen no later than 30 days after their initial appointment, and at a minimum of every six months thereafter.

Psychotherapy has both benefits and risks. Possible risks include the experience of uncomfortable feelings (such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness) or the recall of unpleasant events. Potential benefits include a reduction in feelings of distress, better relationships, better problem-solving and coping skills, and resolution of specific problems. Given the nature of psychotherapy, no guarantees can be made regarding the outcome.

Confidentiality

There is no guarantee of confidentiality under the following conditions:

- If I suspect you/your child are/is in imminent danger of harm to self or others, or a child or elderly person is being abused or neglected (as I am a mandated reporter)
- If a court orders a release of information
- If you initiate a malpractice lawsuit, or a billing dispute with a financial institution
- If your insurance company requests to review your/your child's case
- If you pay by credit card, my name may appear on your credit card statement
- If you do not pay your bill, your balance due statement (including diagnostic and procedural codes)

- may be sent to a collections agency or other responsible party
- Between me and my administrative staff, or colleagues with whom I consult professionally

You confirm you have reviewed my HIPAA privacy practices, available to you as a separate form.

Payment

You agree to pay professional fees as my fee schedule applies. Fee schedule is available if requested.

for in-network providers

For in-network services, I will submit claims on your behalf as a courtesy, but there is no guarantee that your insurance will pay. You are responsible for full payment, whether your insurance company ends up paying partially, or not at all, for services rendered unless otherwise prohibited by your insurance company.

You agree to pay for any time spent in your or your child's care outside of session time on a prorated basis (unless otherwise detailed below). Unfortunately, insurance companies typically do not reimburse for this. Some examples include, but are not limited to:

- No shows/rescheduling with less than **24** business hours notice: Minimum **\$50** service charge. For example, if you or your child's appointment is on Monday at 4pm, you will communicate your cancellation no later than the previous **Friday** at 4pm; if an appointment is on Tuesday at 10am, you will communicate no later than **Monday** at 10am.
- Phone calls, messages in the patient portal, voicemails, letters, video sessions and texts between me and: you, your child, or other physicians, therapists, teachers, family members, insurance companies, etc.
- Prescription refills outside of session time
- Time spent obtaining prior authorizations
- Coordination of care for emergencies, hospitalization, intensive outpatient, residential treatment, rehabilitation, etc.
- All forms (insurance, worker's compensation, school, employer; doctor's notes, letters, or reports) and chart reviews not filled out in session
- Testimony in court, at depositions, administrative hearings, board reviews, and all time required for preparation and travel, whether requested by you or ordered by a court, board, government agency or other legal authority
- There is a **\$5** late fee for balances more than 30 days past due, and they may be submitted to collections after 30 days, along with any associated collections fees
- There is a **\$25** fee for returned checks (which will also result in your credit card automatically being run for the balance due) and for credit card chargebacks that are unsubstantiated

You are financially responsible for all charges, whether or not:

- Insurance pays for any services
- We decide to proceed with treatment
- Treatment is successful, for which there cannot be any guarantee

You affirm you are an authorized user of the credit card whose number and expiration date supplied, and you do authorize its use for all fees incurred.

I confirm I have read the above and agree to these terms and conditions.

Patient/Parent Signature

Date