Cedar Ridge Counseling Centers, LLC

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CRNP Medication Management Clients Consent to Services and Policies

This document is specific to clients receiving treatment with a CRNP at Cedar Ridge Counseling Centers, LLC (CRCC). This document is designed to inform you, the client, to ensure that you understand our professional relationship including its boundaries and policies.

By signing below, you acknowledge that you have read, agreed to, and signed all Cedar Ridge Counseling Centers, LLC required documents including the "Patient information form, policies for clients form, statement of limited confidentiality form, social media policy form, financial policy form, patients' Rights/Responsibilities form, Notice of Privacy Practices /HIPAA acknowledgement form, and informed consent for Telehealth forms". All these policies and acknowledgements are still enforced in addition to the information and policies outlined below.

QUALIFICATIONS and PRACTICE DISCLOSURE

Your assigned provider is licensed by the Board of Nursing in the state of Maryland as a Certified Registered Nurse Practitioner, specializing in psychiatric/mental health, and/or family medicine, and is ANCC board certified. Although your prescriber is a private practice clinician with Cedar Ridge Counseling Centers, LLC, it may become necessary for another Cedar Ridge prescriber to view your medical records to provide coverage if necessary.

TREATMENT

By signing below, you indicate that you consent to medication management and counseling services. The therapeutic relationship is a professional relationship wherein anything you discuss will be held in confidence. The only exceptions being if you disclose information that may directly threaten the well-being or safety of yourself or others or of information indicating possible abuse, which the counselor is obligated to report to appropriate persons or agencies. This applies to both minors and adults. All of our communication becomes part of the clinical record and in addition will abide by all CRCC policies.

You will be a full partner in planning your treatment with your prescriber. This includes the treatment of psychiatric medication management, counseling, and brief therapeutic intervention. If you decide you'd prefer to end counseling services with your prescriber, you have the right to do that at any time. However, medications may be discontinued at any time if any abuse, noncompliance, or misuse is suspected. By signing below, you indicate that you consent to medication management and counseling services and understand and agree that you are obligated to pay in full, any outstanding balance accumulated during the course of treatment and upon termination of the therapeutic relationship (initiated by the client or the counselor). You understand that I must be informed if you are receiving, or plan to receive psychiatric medication management from another provider; I will be happy to coordinate a transition to a new provider should you choose to make a change.

MEDICATION RULES

If medication refills are needed, please email or call your prescriber directly stating your name, the medication(s), and the dosage when you have 7-10 days remaining. It may take up to 72 business hours for a refill request to be completed; please plan ahead and schedule an appointment prior to running out of your medication. You further understand if you do not show or cancel your appointment late and require medications, no changes will be made, and medications will be refilled for maximum of 7 days until you attend the rescheduled appointment. You understand that if you have not attended an appointment for over 6 months, medication will not be refilled; you will be scheduled for a new intake. If you are discharged or terminated for any reason, a 30 days' supply of your medications will be provided. You understand that there are no guarantees of positive outcome for treatment/therapy; you are responsible for providing accurate information about your history, or your child's history. You authorize the release of any information that is needed in order to process any insurance claims, help get preauthorization for visits and / or medications. You will be informed of the goals, expectations, procedures, benefits, and possible risks involved in the evaluation and treatment.

TELEHEALTH

Telehealth services utilizing the HIPAA compliant zoom platform are available which allows for a live audio and visual feed. You understand that Tele-health consultation has potential benefits including easier access to care; you also understand that there are potential risks to this technology, including but not limited to disruption of transmission, interruptions and or breaches of confidentiality by unauthorized persons, technical difficulties, and or a limited ability to respond to emergency. You understand that the decision can be made to discontinue the Tele-health consult/ visit if it is felt that the videoconferencing connections are not adequate for the situation. You understand that if you are experiencing suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth visit services are not appropriate for you. You may require a higher level of care for your immediate crisis. You understand that I may need to contact your emergency contact/ or appropriate authorities in case of emergency. You understand that telehealth visit shall not be recorded by either party unless agreed in writing by mutual consent. Your prescriber accepts most commercial insurances; however,

it is your responsibility to confirm they are in network with your insurance as well as make certain telemedicine for psychiatric medication management is a covered expense prior to starting your session, otherwise you will be responsible for the total fee for service.

EMERGENCY

Your provider operates as a private practice clinician and as a result has various office hours. You will be given the best way to reach your provider at the time of your first appointment; however, if at any time you are experiencing a psychiatric emergency, a life-threatening emergency, and / or medication adverse effect or other life-threatening concerns go to the nearest Hospital Emergency Room or call 911. The Clinician has up to 48 business hours to acknowledge and return calls and emails.

FEES, CANCELLATION, AND INSURANCE REIMBURSEMENT

The self-pay for rate for psychiatric medication management is $200 per initial evaluation and $100 per follow up. You acknowledge that if you decide to use your insurance coverage you will also be responsible for all copays, coinsurance, and or deductibles required by your insurance company and must be paid in full directly to your provider. Your clinician will review their individual payment options with you directly. These options may include but are not limited to the following; invoicing prior to, during, or immediately following your session, cash/check/money order, automatically charging a credit card on file. The above methods may require your clinician to email and/or text using a HIPAA compliant and secure payment method. If your insurance company refuses to pay for any reason, or retracts a payment previously made, you agree to pay any outstanding balance due. It is your responsibility to confirm your provider is in network and covers your required service. Please see CRCC's confidentiality policy for communication that is required with your insurance company.

In the event that you are unable to keep an appointment, you must notify your provider at least 24 hours in advance. If I do not receive such advance notice, you will be responsible for paying $100.00 for the session that you missed. There will be no charge for canceling appointments when at least 24 hours' notice is given. There will be no charge for telephone contact initiated by the client involving treatment issues when the duration of the contact is less than 10 minutes. Email contact may be initiated by the client, but a follow-up appointment may be required if medication changes, or counseling may be needed. Telephone contact exceeding 10 minutes will be treated as a 'session' and billed to your insurance company or as a self-pay follow-up appointment if your insurance does not cover telemedicine services.

DOCUMENT REQUESTS

Document requests can be uploaded through the Cedar Ridge Counseling Centers, LLC. portal and an email sent to your prescriber explaining the need. The provider needs a week minimum for all document requests. This includes school forms, FMLA, etc. Each provider works independently and will determine if the request can be honored, there is no guarantee that FMLA and/or disability paperwork will be completed.

Additional fees will be charged that may or may not be covered by the insurance company: Professional forms/Letters: employment forms, disability, retirement, legal action, etc. Forms may take up to 7 business days from the time of the request to complete. Fees are pro-rated at the hourly rate of $150. If subpoenaed for court the fee is $300 per hour, plus additional fees, if applicable.

TERMINATION OF SERVICES

Any client's services may be terminated for missing two appointments (no-show or less than 24-hour cancellation). Services may also be terminated if the client is dishonest to the point of violating trust and/or the established therapeutic relationship, abuses or misuses medication prescribed, or routinely does not comply with recommended treatment. You may be immediately discharged if your behavior is a threat to your provider, exhibits emotional intimidation, verbal abuse of any kind; sending abusive messages or phone correspondence/email correspondence. If treatment is terminated, a notice of termination letter will be sent to the address of file, and I will send in for a thirty-day supply of medications to the pharmacy on file unless refills have already been on file for said medication and/or the medication was not taken as prescribed (non-compliance, misuse or abuse). Services may also be terminated if a balance goes unpaid after being attempted to collect for three weeks.

CONSENT TO TREAT

By signing below, you indicate that you consent to medication management and counseling services and understand and agree that you are obligated to pay in full, any outstanding balance accumulated during the course of treatment and upon termination of the therapeutic relationship (initiated by the client or the counselor). In addition, if you do not pay for your sessions within two weeks, treatment will be suspended until payment has been made or a payback schedule has been mutually agreed upon. All balances must be paid, in full, at the end of each calendar year. By signing below, you indicate that you have read this contract in full, and both understand and agree to its contents. You may revoke this consent in writing except to the extent that action has been taken to relying on this consent prior to being revoked.

Signed by (print): _____ **Relationship to client: _____**

Signature: _____ **Date Signed: _____**