Patient: _____

DOB: _____ **ID:** _____

Consent for Evaluation and Treatment

Patient or patient's legal representative agree to the following terms for encounters with Brain Solutions PLLC (BS):

1. **Treatment**: The patient consents to the treatment and services provided by Brain Solutions which may include but are not limited to: psychotherapy, psychiatric services, evaluating patients before prescribing medications, refilling existing prescriptions, regular monitoring of medication use, behavioral healthcare, and any necessary periodic laboratory tests.
2. **Release of Information**: The patient acknowledges and agrees that any health and/or financial information (including information regarding alcohol or drug abuse, HIV related or to other communicable disease related information) may be released to the following:
    a. Healthcare providers or their agents who are providing or have provided healthcare to the patient; any individual or entity responsible for payment of BS's charges; to health care providers or organizations.
    b. All BS staff members, contractors, business associates, service locations, facilities and services and associated staff, and contractors.
    c. Individuals and entities as specified by law, ethical standards, and per insurance billing requirements.
    d. Patients covered under Arizona Medicaid System benefits waive the right to confidential disclosure with their Primary Care Physician.
3. **Contraband**: Drugs, alcohol, weapons, and other articles specified as contraband by BS may not be brought onto BS premises. Any illegal substance will be confiscated and turned over to law enforcement authorities.
4. **Dismissal From Provider Services or BS**: Patient may be dismissed from provider care or BS for:
   1. Excessive no-shows/late arrivals, 2. Inappropriate or disruptive behavior, 3. Failure to follow treatment recommendations, 4. Medication dishonesty, 5. Failure to meet financial obligations, 6. Providing false or inadequate information, 7. Failing to authorize the release of records to BS or, 8. Being a difficult patient.
5. **Teaching Program**: BS participates in training programs for therapists and health care personnel. Some patient services may be provided by persons in training, under the supervision and instruction of therapists or other BS providers and/or contractors. These persons in training may also observe care given to the patient by therapists and BS providers and/or contractors. Patient will be notified if treatment is being provided by an unlicensed provider who is directly supervised by a licensed provider. With consent, any observation (e.g. video-taped or audio-taped) by a provider supervisor will be used strictly for educational purposes. Any questions regarding supervision will go to the Clinical Director, Jonathan C. Mackey, LCSW.
6. **Communication**: I understand that BS may: ___Call or ___Text at this number:_____

   Or email:_____

   I authorize the following individuals to inquire and receive verbal information regarding my care.

   _____
7. **Terms of the Agreement**: This agreement shall remain in effect as long as I am seeking services from BS. I acknowledge that I have read, understood, and agree to the terms and conditions as outlined in the patient information packet. I may be asked to sign a new agreement every year. This release shall continue for so long as the medical/behavioral health and/or financial records are needed for payment, treatment, or healthcare operations.

I acknowledge receipt of the Notice of Privacy Practices, Patient Rights, and the Notice of Health Information Practices, this includes information regarding the participation of BS in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy. I am the patient or the legal representative of the patient and am authorized to act on the patient's behalf to sign this agreement. This includes my email and phone communication preferences.

_____ _____

Patient/Authorized Representative | Relationship to Patient

_____ _____

Witness (Printed Witness/Staff Name/ Signature) | Date/Time

Patient: _____

DOB: _____ ID: _____

Telehealth Informed Consent

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, video conferencing, transmission of still images, patient portal, remote patient monitoring are all considered telehealth services.

The patient hereby gives Brain Solutions PLLC consent and authorization to participate with Brain Solutions PLLC and its affiliates in telehealth program. This may consist of but not limited to Zoom, Facetime, and Cisco Web, or Google Hangouts which are privacy optimized. Brain Solutions PLLC, may or may not a formal business associate agreement in place with those services (and no such agreements are available with Facetime), which may create technical statutory Privacy issues. Patient consents to those third-party services

Please Initial the following:

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this time.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of Arizona at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- It is easier for electronic communications to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
- Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
- Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

I acknowledge receipt of the Notice of Telehealth Services. I am the patient or the legal representative of the patient and am authorized to act on the patient's behalf to sign this agreement. This includes my email and phone communication preferences.

_____ _____

Patient/Authorized Representative Relationship to Patient

_____ _____

Witness (Printed Witness/Staff Name/ Signature) Date/Time