TMR MENTAL HEALTH CARE PC

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INFORMED CONSENT

MENTAL HEALTH CARE PROVIDER-CLIENT SERVICE AGREEMENT

Welcome to our private practice. TMR which stands for Treat Me Right (TMR) Mental Health Care PC. This document contains important information about professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOTHERAPEUTIC SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. TMR, as your mental health care provider, has corresponding responsibilities to you. These rights and responsibilities are described in the following sections. Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. To be most successful, you will have to work on things discussed outside of

sessions.
The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, your mental health care provider will be able to offer you some initial impressions of what our work might include. At that point, they will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with our practice. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments will ordinarily be 30-60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, we ask that you provide us with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24-hour notice, our policy is to collect the amount of $100 for prescribers such as Dr. Patria Gerardo, Kirt Lewis, Akosua Karikari and Caroline Wiltshire. We will charge $95 for Licensed Clinical Social Workers (LCSW), Licensed Professional Counselors (LPC), Doctor of Psychology (PsyD), Licensed Marriage and Family Therapists (LMFT), and $50 for psychotherapists under supervision with the credentials LSW / LAC/ Psychotherapists in Training (interns). [unless we both agree that you were unable to attend due to circumstances beyond your control].

Please note that this policy also applies to missed intake appointments, which will be charged a $100 fee.

It is important to note that insurance companies do not provide reimbursement for canceled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, we will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

I acknowledge that these terms have been reviewed and agreed upon prior to the start of service provision. I agree to these terms for my minor child if I am signing on behalf of a minor child.

IN-PERSON VISITS & SARS-CoV-2 ("COVID-19")

If you attend therapy in-person, you understand:

• You can only attend if you are symptom-free
• If you are experiencing symptoms, you can switch to a telehealth appointment or cancel. If you need to cancel, you will not be charged a late cancellation fee.

• You must follow all safety protocols established by the practice, including:

• Following the check-in procedure;

• Washing or sanitizing your hands upon entering the practice;

• Adhering to appropriate social distancing measures;

• Wearing a mask, if required;

• Telling your Provider if you have a high risk of exposure to COVID-19, such as through school, work, or commuting; and

• Telling your Provider if you or someone in your home tests positive for COVID-19.

• Your Provider may be mandated to report to public health authorities if you have been in the office and have tested positive for infection. If so, your Provider may make the report without your permission, but will only share necessary information. Your Provider will never share details about your visit. Because the COVID-19 pandemic is ongoing, your ability to meet in person could change with minimal or no notice. By signing this Consent, you understand that you could be exposed to COVID-19 if you attend in-person sessions. If a member of the practice tests positive for COVID-19, you will be notified.

POLICIES OF CONFIDENTIALITY & PRIVILEGE

For many, the decision to see a therapist is an extraordinarily private one. People come to TMR with the expectation that the information that they will share with TMR clinicians will remain private. This expectation is a reasonable one, and in fact, in most instances, a psychotherapist or counselor has a legal obligation to keep clients' confidences and information private. There are of course some exceptions.

The following is a brief outline of the constraints that a health care provider is under regarding keeping information regarding clients private.

Health Insurance Portability and Accountability Act of 1996 "HIPAA".

Title I of HIPAA was passed in 1996. Title, I protect health insurance coverage for workers and their families who change or lose their jobs. Title II of HIPAA requires the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. Title II also addresses the security and privacy of health data, which is the section of the Act important for our purpose. Title II of HIPAA requires medical providers to protect the privacy of patients' medical information by controlling the manner in which a patient's "protected health information" is used and disclosed. Under HIPAA, patients must be offered certain rights with respect to their information, such as the right to access and copy, the right to request amendments to the information contained in their file, and the right to request an accounting. Medical providers must have proper policies and procedures in place to further protect the privacy of patients' information. Under HIPAA, medical information can be shared with other health care providers for treatment purposes only. HIPAA does not permit mental health professionals to share personal psychotherapy notes of patients, even for treatment purposes, without the patient's authorization.

There are exceptions under HIPAA, which allow medical providers to disclose protected health information under the following situations:

1) Suspected Abuse or Neglect: If the medical provider believes that the patient has been a victim of abuse, neglect or domestic violence protected information may be released. The report must be made to a person authorized by law to receive reports of child abuse or neglect.

2) Serious or Imminent Threat: If the provider believes that disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, protected information may be released to the appropriate authority. 3) Law Enforcement: If disclosure is necessary for law enforcement authorities to identify or apprehend an individual.

I acknowledge that these terms have been reviewed and agreed upon prior to the start of service provision.

INSURANCE INFORMATION (Your responsibilities include):

Verifying your plan's limitations, deductibles, and exclusions, prior to your first appointment. It is important that you understand your benefit coverage. For benefit coverage questions, please call the customer or member service phone number on the

back of your insurance card. You will receive an Explanation of Benefits (EOB) from your insurance company detailing charges, amounts you are responsible for and amounts they have paid to TMR.

Pay your fee for services at the time they are rendered. In compliance with health insurance contracts, TMR requires that all co-payments are collected at the time of service. This includes payments towards coinsurance and deductibles. In some cases, the co-insurance/deductible amount collected will be an estimate and adjustment will be made once a response is received from your insurance company regarding the claim. This may result in a credit to your account or additional charges.

Provide us with a copy of your insurance cards and update us if any changes occur with your coverage. Please also notify us of any changes in address or other contact information. **If the insurance information you provide to us is later determined to be inaccurate resulting in a denial of your claim, you will be responsible to pay the amount denied by your carrier. If you refuse to pay your debt, TMR reserves the right to use an attorney or collection agency to secure payment. Late fees and costs to hire an attorney or collection agency will be applied to payments not received within 30 days of service provision.**

I authorize TMR to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to TMR. If I am to receive any payment from my insurance company directly, I agree to submit the payment to TMR immediately upon receipt. I understand that I am responsible for payment for services rendered by TMR regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify TMR immediately whenever there are changes in my health condition or health plan coverage in the future.

FINANCIAL AGREEMENT

TMR attempts to make psychotherapy affordable by accepting insurance provider payments and by using an adjustable fee scale for clients who do not have insurance. Fees will be discussed during your initial contacts with our staff. We can bill insurance, but coverage varies according to each insurance plan. We encourage you to check with your carrier in advance to verify your mental health/ behavioral health coverage. Most providers at TMR are In-Network with most insurance panels. Our billing providers on staff are “In Network” with various insurance panels**.** Rest assured, that you will never receive any “surprise bills” from TMR. Billing will be done the best way to keep your out-of-pocket costs affordable, and we do all the leg work. Any copays, deductibles, co-insurance, or out of pocket costs will be explained and agreed upon before the start of treatment. If you have any questions when you receive an “Explanation of Benefits”

or (EOB) from your insurance company. Do not hesitate to call us, we will answer all your questions.

For clients who are not using insurance or paying privately, we can offer an adjustable fee schedule. **You will be required to keep a credit card on file, if you are a self-paying patient or being seen virtually.** Charges will be made the day of each scheduled session. If a patient with no insurance coverage cannot afford the minimum amount on the adjustable fee scale, TMR will make an appropriate referral to a mental health provider or organization that is free of charge.

Payment is expected at the time of service unless arrangements are made in advance with the Billing Department. **For patients who are being seen remotely, a credit card is required on file.** Payments not received within 72 hours will lead to any upcoming scheduled appointments to be canceled. TMR accepts the following forms of payments: cash, MasterCard, Visa, American Express, and Discover. We also accept HSA and FSA accounts. Overdue balance not paid within 30 days, will be sent to collections. Any additional fees incurred by TMR as a result, will be the responsibility of the patient.

Fees range from $185 - $500 per session. Fees can vary depending on type of therapy and length of session. Fees for other services (letters, phone calls, consultations, etc.) vary for each therapist and will be discussed as needed. We do offer a sliding scale for clients who pay privately. I have read, understood, and agreed to TMR's Financial Agreement. I understand that I am ultimately responsible for payment to TMR for all services rendered and that such payment is due at the time of the visit. Late fees will be applied to payments not received within 6 days of service provision. My signature below indicates that I fully understand and agree to these terms.

CANCELLATION OR MISSED SESSION FEES

Please be aware that TMR is not able to reserve a regularly scheduled appointment time for clients who frequently cancel, reschedule, or miss appointments—especially without giving 24-hour notice. TMR requires you to keep a credit card on file to charge for missed appointments. The cost for a missed session or late cancellation is $100, including missed **intake appointments**. Any client who misses, cancels, or reschedules two consecutive sessions, or who is non-compliant with treatment recommendations, will be discharged from our practice.

PROFESSIONAL RECORDS

We are required to keep appropriate records of the mental health / behavioral health services that we provide. Your records are maintained in a secure location electronically. We keep brief records noting that you were here, your reasons for seeking mental health care, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records we receive from other providers, copies of records we send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. In a private practice setting, it is essential to uphold the principles of informed consent regarding the management of professional records. Psychotherapists are committed to maintaining the confidentiality and integrity of their clients' sensitive information. While clients have the right to access their records, psychotherapists reserve the right **not to share psychotherapy notes** that contain personal reflections, clinical observations, and other subjective information used for treatment planning and decision-making. This practice is grounded in the ethical obligation to protect the therapeutic process and ensure that the notes remain a safe space for open and honest dialogue. Patients will be provided dates of treatment, medication lists (if applicable) and diagnosis.

PARENTS & MINORS

While privacy in mental health care is crucial to successful progress, parental involvement can also be essential. It is our policy not to provide treatment to a child under age 13 unless s/he agrees that we can share whatever information we consider necessary with a parent. For children 14 and older, we request an agreement between the client and the parents allowing us to share general information about treatment progress and attendance, as well as a treatment summary upon completion of treatment. All other communication will require the child's agreement, unless we feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case we will make every effort to notify the child of our intention to disclose information ahead of time and make every effort to handle any objections that are raised.

Please be advised that under no circumstance will any person be permitted to make decisions or request information regarding an established TMR patient. A Healthcare Power of Attorney is a legal document that gives a trusted person or entity the authority to make medical decisions on your behalf, if you are incapacitated or cannot do so on your own. Patients 18 years of age or older, must contact the office directly to request prescriptions, make appointments, and to address any questions or concerns regarding their care unless they have a Health Care Power of Attorney on file in their record.

CONTACTING US

We are often not immediately available by telephone. We do not answer our phones when we are with clients or otherwise unavailable. At these times, you may leave a message on our confidential voicemail. Your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unforeseen reasons, you do not hear from us or we're unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) If you or a family member are experiencing the signs or symptoms of a mental illness and feel you are in crisis, and live in Bergen County call **New Jersey call 201-262-HELP (4357).** Bergen County's designated Psychiatric Emergency Screening Program by CarePlus NJ. The purpose of 262-HELP is to provide emergency mental health services to residents of Bergen County. If you live outside of Bergen County go to your Local Hospital Emergency Room, or **call 988 (Suicide and Crisis Lifeline)** or **911** and ask to speak to the mental health worker on call.

If you live in New York, Text "**WELL**" to 65173 or call 1-888-**NYC**-**WELL**. Crisis counselors are available 24/7 to guide you through the next steps of getting help.

We will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering your clinical team, when and if an absence occurs.

OTHER RIGHTS

If you are unhappy with what is happening in treatment, we hope you will talk with us so that we can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that we refer you to another mental health care provider and are free to end treatment at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about our specific training and experience.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this agreement and the Notice of Privacy Practices and agree to their terms**.**

The following has been discussed with me regarding the use of telehealth for services provided by TMR, staff, and affiliates.

· Scheduling
· Privacy/security measures
· Potential risks
· Mandatory reporting requirements
· Credentials of care team
· Billing arrangements
· Limits to confidentiality
· Explicit emergency plan
· Storage of patient information and potential for technical failure
· Procedures for coordinating care
· Protocols for contact between visits
· Prescribing policies (including local and federal regulations)
· Conditions where telehealth should be terminated for in-person care.

I hereby give my informed consent for the use of telehealth in my medical and mental health care.

You have provided us with the name and contact information for your Next of Kin, or person you'd like us to contact in the event of the emergency.
By signing this form you permit us to share or discuss information regarding your care (such as progress towards your goals, treatment planning, scheduling, insurance claims, or collecting payments) with this person.

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATIONS

I, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment with the use of psychotropic medications.

Your physician or Psychiatric Mental Health Nurse Practitioner will prescribe psychotropic medication(s) after a thorough assessment of your needs, presenting symptoms, and current level of functioning and impairment.

To make an informed decision, you must be provided with information verbally (in

your sessions) and/or written including the following:

1. The nature of your psychiatric condition (diagnosis).
2. The reasons for taking such medication(s), include the likelihood of improving or not improving without such medication(s).
3. The name, dosage, frequency, route of administration and duration of prescribed medication(s).
4. The possible side effects of the medication(s) known to commonly occur and may possibly cause birth defects.
5. Additional side effects may occur with continued administration of an Antipsychotic medication(s) if taken for more than three (3) months. Side effects may include persistent involuntary movements of the face, mouth, limbs, and trunk, called tardive dyskinesia. These symptoms may be irreversible and may continue to appear even after the medication(s) has been discontinued.
6. Duration and continuation of medication(s) will be discussed with you and your treating Psychiatrist/Nurse Practitioner during each visit.

Your signature below acknowledges that:

1. Medication(s) and treatment have been adequately discussed with you and should be taken only as prescribed.
2. You have received all the information you desire concerning such medication(s) and treatment.
3. I have been offered a Medication Information Sheet(s) and have had an opportunity to review with the prescriber the specific benefits and side effects of prescribed medicine(s).
4. We ask that you keep medication management appointments as scheduled. This ensures that you are monitored and receive the best quality of care. Frequent no shows or cancellations will result in discharge from our practice.
5. If you do not keep appointments as scheduled and need a medication refilled between sessions or if you run out of your medication, you will only be prescribed enough medication until your next
scheduled appointment. It is important to our care team that you are monitored appropriately while taking medication.
6. Children under the age of 16 years old will be required to have a completed Neurodevelopmental Evaluation by a Developmental Pediatrician or Neurologist before any medication will be prescribed for attention deficit hyperactivity disorder (ADHD).

I hereby give my consent to treatment with this medication. I understand that I may seek additional information, and that I may withdraw this consent at any time by stating my intention to any member of the treatment team.

Medication Management Agreement - Benzodiazepines

This agreement between (Patient) and the Providers for TMR MENTAL HEALTH CARE PC (TMR) is to agree on clear conditions for the use of benzodiazepines. I understand that this agreement is important for my safety and helps keep the trust needed in a provider/patient relationship.

I understand the following about benzodiazepine medications:

- If I use a Benzodiazepine daily, they will become less effective over time
- I could suffer withdrawal symptoms if I stop a benzodiazepine suddenly ● Benzodiazepine withdrawal can be deadly in some cases
- There is a risk of addiction with benzodiazepine use
- Benzodiazepines have multiple long-term side effects, including memory disturbance and increased risk for Alzheimer's Disease
- I understand that the main goal of treatment with these medications is to improve overall quality of life.
- I understand that taking these medications may reduce my ability to concentrate, think clearly, or react quickly. I will not drive or operate dangerous machinery until I am sure I can do so safely.
- Some other side effects of these medications include the following: fatigue, depression, unsteadiness, low blood pressure, sleepiness, seizures, nervous feelings, and difficulty breathing. I will notify an TMR provider if any of these side effects occur.
- I understand that using these medications to treat my condition may result in dependence on the medication. Abruptly stopping these medications can lead to symptoms of withdrawal, such as fast heart rate, high blood pressure, fever, agitation, seizures, and hallucinations.
- I understand that withdrawal is uncomfortable, and possibly life-threatening. For my safety, if I stop my medication for any reason, I will do so under the guidance of an TMR provider.
- (FOR WOMEN) Benzodiazepine medications can be harmful to developing babies. To the best of my knowledge, I am not currently pregnant, and I agree to pregnancy tests. If there is a chance I could get pregnant, I agree to use birth control methods to avoid becoming pregnant. I will disclose to my provider if I plan to become pregnant.

These medications are often abused and are extremely dangerous when used improperly. For this reason, and others, I understand and agree to the following conditions regarding my use of medications:

● I will only take medications at the dose and frequency prescribed by my provider
● I will not change how I take these medications without the prior approval of my provider. My provider may stop filling my medication if I change the way I take it without approval. This may result in withdrawal or overdose symptoms, which could result in death.
● I will not request early refills. I understand that prescriptions will not be refilled early under ANY circumstances. Lost, damaged, stolen, or otherwise misplaced medications will not be refilled prior to the next scheduled refill date. I am responsible for my medications.
● All prescriptions will be written, at maximum, on a 30-day schedule unless otherwise noted·
● I will not request these types of medications from ANY other providers without the approval of my TMR provider. If offered benzodiazepines from another medical provider, I will tell the provider about my agreement. This includes the emergency room, urgent care, prompt care, and other similar medical facilities.
● I will keep my medication list updated and current with TMR, all medications, including over the counter, herbal products, and vitamins.
● I will keep appointments with my psychiatric provider at TMR as scheduled ● I will actively participate in the treatment plan as described by my provider, this could be psychotherapy, individually or with my family, nutrition counseling, among other things. I agree to fully participate in other treatment therapies that may be recommended by an TMR provider. Medications are given as part of an overall treatment program.
● I agree that I will not use any mood-altering drug, marijuana, alcohol, or other illicit substances while taking this medication. This includes medical marijuana, cocaine, or methamphetamines.
● I agree that I may be subject to random urine drug screens and pill counts ● I understand that if my urine drug screen indicates that I am not taking these medications my provider will stop these medications
● I understand that if my pill count suggests that I am taking the medication differently than prescribed my provider will stop these medications
● I will not sell, trade, or give my prescription medication to anyone. I will keep these medications away from children
● I understand that failure to comply with the above may cause my provider to STOP prescribing these medications
● I understand that if I do not show improvement in symptoms that my provider may stop prescribing these medications. My medication may also be stopped if an TMR provider believes that using these medications is not helping to improve my function and/or is harming me in any way.
● I understand that my provider may stop these medications if I show significant side effects from these medications or demonstrate a problematic tolerance ● If

my provider stops prescribing me benzodiazepines, they will stop them in the safest manner possible.

- I agree to allow TMR to request information from any healthcare provider or pharmacy about all my medications.
- I agree that regular attempts to reduce dosage and/or develop other approaches to manage symptoms will be part of the plan. I will participate in and cooperate with this plan.

I understand that the use of benzodiazepine medications may be stopped if the medication does not improve my ability to function, if unacceptable side effects develop, or if I do not follow all parts of this agreement. The purpose, risks, and potential benefits of using these medications have been explained to me by my provider and include the following:

I will only fill my prescriptions at the pharmacy on file in my medical record. If I need to change my pharmacy, I will notify my provider. I may be asked to sign a new agreement. Undocumented changes in my filling pharmacy may result in a delay or denial of my medication.

I understand that an TMR provider will discontinue benzodiazepine therapy if I do not meet the terms of any part of this agreement for any reason. I understand that this agreement will become part of my permanent medical record. I have read this document, or had it read to me, and I understand it and have had all questions answered to my satisfaction. My provider has reviewed the above with me. I have read this agreement and agree to all terms as outlined above.

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included. I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.