

# Inner Self Care Practice Policies



As the patient, I give permission and Consent for my Inner Self Care practitioner to:

-To provide me with medical treatment.

I understand that my provider does file insurance; though may not be in-network with my insurance carrier and I may contact my insurance company, privately, in an attempt to file reimbursement on my own, if desired.

I understand and agree:

- I must pay my balance immediately or services will discontinue
- I must pay for the cost of these services not covered by my insurance

I understand and agree:

- I have the right to refuse any treatment
- My Provider is not liable for treatment I consented to
- I have the right to discuss all medical treatments with my provider

## The Treatment Process

Treatment is a collaborative process where you and your Provider will work together on equal footing to achieve goals that you define. This means that you will follow a defined process supported by scientific evidence, where you and your provider have specific rights and responsibilities. Treatment generally shows positive outcomes for individuals who follow the process. Better outcomes are often associated with a good relationship between a patient and their provider. To foster the best possible relationship, it is important you understand as much about the process before deciding to commit.

Treatment begins with the intake process/patient's first appointment.

- 1.)First, you will review, sign and submit all treatment documents, talk about fees, identify emergency contacts, and ask your provider any questions you may have or any questions that arise from information given to me by my provider.
- 2.)Second, you will discuss what to expect during treatment, including but not limited to: the length of treatment, and the risks and benefits.
- 3.)Third, you will form a treatment plan, including but not limited to: How often you will be seen by your provider, your short- and long-term goals, and the steps you will take to achieve them. Over time, you and your Provider may edit your treatment plan to be sure it describes your goals and steps you need to take. After intake, you will attend regular appointments through video, called telehealth.

## TELEHEALTH SERVICES

To use telehealth, you need an internet connection and a device with a camera for video. Your Provider can explain how to log in and use any features on the telehealth platform. If telehealth is not a good fit for you, your Provider will recommend a different option. There are some risks and benefits to using telehealth:

- Risks
- Privacy and Confidentiality. You may be asked to share personal information with the telehealth platform to create an account, such as your name, date of birth, location, and contact information. Your Provider carefully vets any telehealth platform to ensure your information is secured to the appropriate standards.
- Technology. At times, you could have problems with your internet, video, or sound. If you have issues during an

appointment, your Provider will follow the backup plan that you agree to prior to your appointment(s).

- **Crisis Management.** It may be difficult for your Provider to provide immediate support during an emergency or crisis. You and your Provider will develop a plan for emergencies or crises, such as choosing a local emergency contact, creating a communication plan, and making a list of local support, emergency, and crisis services.

- **Benefits**

- **Flexibility.** You can attend treatment wherever is convenient for you.

- **Ease of Access.** You can attend telehealth appointments without worrying about traveling, meaning you can schedule less time per appointment and can attend treatment during inclement weather or illness.

- **Recommendations**

- Make sure that other people cannot hear your conversation or see your screen during your appointments.

- Do not use video or audio to record your appointment unless you ask your Provider for their permission in advance.

- Make sure to let your Provider know if you are not in your usual location before starting any telehealth appointment.

## CONFIDENTIALITY

Your Provider will not disclose your personal information without your permission unless required by law. If your Provider must disclose your personal information without your permission, your Provider will only disclose the minimum necessary to satisfy the obligation. However, there are a few exceptions.

- Your Provider may speak to other healthcare providers involved in your care.

- Your Provider may speak to emergency personnel.

- If you report that another healthcare provider is engaging in inappropriate behavior, your Provider may be required to report this information to the appropriate licensing board. Your Provider will discuss making this report with you first, and will only share the minimum information needed while making a report. If your Provider must share your personal information without getting your permission first, they will only share the minimum information needed. There are a few times that your Provider may not keep your personal information confidential.

- If your Provider believes there is a specific, credible threat of harm to someone else, they may be required by law or may make their own decision about whether to warn the other person and notify law enforcement. The term specific, credible threat is defined by state law. Your Provider can explain more if you have questions.

- If your Provider has reason to believe a minor or elderly individual is a victim of abuse or neglect, they are required by law to contact the appropriate authorities.

- If your Provider believes that you are at imminent risk of harming yourself, they may contact law enforcement or other crisis services. However, before contacting emergency or crisis services, your Provider will work with you to discuss other options to keep you safe.

## RECORD KEEPING

Your Provider is required to keep records about your treatment. These records help ensure the quality and continuity of your care, as well as provide evidence that the services you receive meet the appropriate standards of care.

## COMMUNICATION

You decide how to communicate with your Provider outside of your appointments. You have several options:

- **Texting/Email**

- Texting and email are not secure methods of communication and should not be used to communicate personal information. You may choose to receive appointment reminders via text message or email. You should carefully consider who may have access to your text messages or emails before choosing to communicate via either method.

- **Secure Communication**

- Secure communications are the best way to communicate personal information, though no method is entirely without risk. Your Provider will discuss options available to you. If you decide to be contacted via non-secure methods, your Provider will document this in your record.

- **Social Media/Review Websites**

- If you try to communicate with your Provider via these methods, they will not respond. This includes any form of friend or contact request, @mention, direct message, wall post, and so on. This is to protect your confidentiality and ensure appropriate boundaries in treatment.
- Your provider may publish content on various social media websites or blogs. There is no expectation that you will follow, comment on, or otherwise engage with any content. If you do choose to follow your Provider on any platform, they will not follow you back.
- If you see your Provider on any form of review website, it is not a solicitation for a review. Many such sites scrape business listings and may automatically include your Provider. If you choose to leave a review of your Provider on any website, they will not respond. While you are always free to express yourself in the manner you choose, please be aware of the potential impact on your confidentiality prior to leaving a review. It is often impossible to remove reviews later, and some sites aggregate reviews from several platforms leading to your review appearing in other places without your knowledge.

## FEES AND PAYMENT FOR SERVICES

You may be required to pay for services and other fees. This provider does not/may not accept insurance. You will be provided with these costs prior to beginning treatment. You should also know about the following:

- No-Show and Late Cancellation Fees
- If you are unable to attend your scheduled appointment, you must contact your provider 24 hours before your scheduled appointment. Otherwise, you may be subject to fees outlined in your fee agreement.
- Balance Accrual is not permitted
- Full payment is due at the time of your appointment. If you are unable to pay, tell your Provider. Your Provider may offer payment plans or a sliding scale. If not, your Provider may refer you to other low- or no-cost services. Any balance due will continue to be due until paid in full. If necessary, your balance may be sent to a collections service.
- Administrative Fees
- Your Provider may charge administrative fees for writing a letter or report at your request; consulting with another healthcare provider or other professional outside of normal case management practices; or for preparation, travel, and attendance at a court appearance. These fees are listed in the fee agreement. Payment is due in advance.
- Insurance Benefits, if applicable
- Before starting treatment, you should confirm if your provider accepts insurance

**If** insurance is accepted by your treatment provider, it is important to check the following with you insurance company to see if:

- Your benefits cover the type of treatment you will receive;
- Your benefits cover telehealth appointments;
- You may be responsible for any portion of the payment; and
- Your Provider is in-network or out-of-network.
- Sharing Information with Insurance Companies
- If your provider accepts and you choose to use insurance benefits to pay for services, you will be required to share personal information with your insurance company. Insurance companies keep personal information confidential unless they must share to act on your behalf, comply with federal or state law, or complete administrative work.
- Covered and Non-Covered Services
- When your Provider is in-network, they have a contract with your insurance company. Your insurance plan may cover all or part of the cost of treatment. You are responsible for any part of this cost not covered by insurance, such as deductibles, copays, or coinsurance. You may also be responsible for any services not covered by your insurance.
- When your Provider is out-of-network, they do not have a contract with your insurance company. You can still choose to see your Provider; however, all fees will be due at the time of your appointment with your Provider. Your Provider will tell you if they can help you file for reimbursement from your insurance company. If your insurance

company decides that they will not reimburse you, you are still responsible for the full amount. \* ***Providing this information does not guarantee that your provider accepts insurance. I understand and agree that my provider may not accept my health insurance or health insurance in general. I also understand and agree that I am responsible for payment of services regardless of my provider's status of accepting health insurance.***

- **Payment Methods**

- The practice may require that you keep a valid credit or debit card on file. This card will be charged for the amount due at the time of service and for any fees you may accrue unless other arrangements have been made with the practice ahead of time. It is your responsibility to keep this information up to date, including providing new information if the card information changes or the account has insufficient funds to cover these charges.

## **COMPLAINTS**

If you feel your Provider has engaged in improper or unethical behavior, you can talk to them, or you may contact the licensing board that issued your Provider's license, your insurance company (if applicable), or the US Department of Health and Human Services.

## **Acknowledgement**

My signature on this document represents that I have received the Consent for Services form and that I understand and agree to the information therein. Further, I consent to use an electronic signature/physical signature (patient's choice) to acknowledge this agreement.

## **Informed Consent for Telehealth Services**

### **- I understand that Telehealth is my provider's primary source of treatment**

- I understand that telehealth is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.

- I understand that telehealth treatment can present the opportunity for technical difficulties, and should technical issues occur, I will **email** my provider to inform him/her of the issue and agree on how to proceed

- If my provider is experiencing technical issues, your provider will reach out via **email** and you both will agree how to proceed (rescheduling, phone conversation, etc.).

- I understand that if I am experiencing technical difficulties, and fail to reach out to my provider **via email** to make other arrangements, I will be responsible for a \$99 Missed Appointment Fee.

- I understand that the telehealth visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.

- I understand that the laws that protect privacy and the confidentiality of medical information including (HIPAA) also apply to telehealth.

- I understand that I will be responsible for any additional fees that apply to my telehealth visit. - I understand that telehealth can create breaches of privacy if I am in the presence of others. My provider will not be responsible for any breaches of privacy created by me to which he/she has no control over.

- I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, and if I choose to withdraw my telehealth consent, I will not be able to receive

treatment since telehealth is my provider's primary source of treatment.

- I understand that by signing this form that I am consenting to receive health care services via telehealth
- I understand that I am giving my provider consent to email and text me my appointment link to access virtual appointments.
- Appointment Links will be sent to the email address provided by the patient

**Patient Email Address:** \_\_\_\_\_

**Patient Name (Print):** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

In compliance with the No Surprises Act that went into effect January 1, 2022, all healthcare providers are required to notify patients of their federal rights and protections against potential “surprise billing.”

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by an out-of-network provider, if a patient is uninsured, or if a patient elects not to use their insurance.

Additionally, we are required to provide you with a Good Faith Estimate of the cost of services. It is difficult to determine the true length of treatment for mental health care. Therefore, below you will find a fee schedule for the services offered by your provider with the estimated yearly cost for each service.

**Post Intake/First Appointment:**

Upon completion of your first appointment, your provider will email you an updated revised good faith estimate, which should include your diagnosis, estimated number of yearly sessions and total cost of services for 12 months. You are required to sign an updated good faith estimate within **48 hours of your first appointment.**

Please review the Good Faith Estimate, below, and let your provider know if you have any questions. Please sign below for acknowledgment of receipt of this document and/or acknowledgment of receipt of this document is located on the general patient consent to treat form.

**New Patient Medication Evaluation /First Appointment**

Typically lasts for: **Up to 60 Minutes**

**New Patient Medication Evaluation /First Appointment *Total Estimate: \$150.00***

**Follow Up Appointments/Medication Review/Medication Management**

\$ 75.00/ Appointment (Up to 30 Mins)

For follow up appointments, patients are typically seen, at minimum, on a monthly basis until medication is completely stable. **\*Please keep in mind that you may be required to see your provider more often depending on your individualized circumstance.**

**Patient Total Yearly Estimate Follow Up Appointments/Medication Management:**

11 Months at once/month at \$75.00/ Appointment

**Total Estimate for Minimum Follow Up Appointments: \$825.0**

**Patient Total Yearly Estimate Follow Up Appointments/Medication Review/ Medication-Management (Bi-Monthly/Twice per Month) :**

11 Months at twice/month at \$75.00/ Appointment

**Total Estimate for Bi-Weekly Follow Up Appointments: \$1650.00**

**Good Faith Estimate:**

My signature on this document represents that I have received a pre-evaluation Good Faith Estimate and I understand and agree to the information therein. Further, I consent to use an electronic signature/physical signature (patient's choice) to acknowledge this agreement.

**Patient Name (Print):** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your practitioner is committed to protecting your privacy. The Practice is required by federal law to maintain the privacy of Protected Health Information ("PHI"), which is information that identifies or could be used to identify you. The Practice is required to provide you with this Notice of Privacy Practices (this "Notice"), which explains the Practice's legal duties and privacy practices and your rights regarding PHI that we collect and maintain.

**YOUR RIGHTS**

Your rights regarding PHI are explained below. To exercise these rights, please submit a written request to the Practice at the address noted below.

To inspect and copy PHI.

- You can ask for an electronic or paper copy of PHI. The Practice may charge you a reasonable fee.
- The Practice may deny your request if it believes the disclosure will endanger your life or another person's life. You may have a right to have this decision reviewed.

To amend PHI.

- You can ask to correct PHI you believe is incorrect or incomplete. The Practice may require you to make your request in writing and provide a reason for the request.
- The Practice may deny your request. The Practice will send a written explanation for the denial and allow you to submit a written statement of disagreement.

To request confidential communications.

- You can ask the Practice to contact you in a specific way. The Practice will say “yes” to all reasonable requests.

To limit what is used or shared.

- You can ask the Practice not to use or share PHI for treatment, payment, or business operations. The Practice is not required to agree if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask the Practice not to share PHI with your health insurer. ***\*This provider does not/may not accept insurance.***
- You can ask for the Practice not to share your PHI with family members or friends by stating the specific restriction requested and to whom you want the restriction to apply.

To obtain a list of those with whom your PHI has been shared.

- You can ask for a list, called an accounting, of the times your health information has been shared. You can receive one accounting every 12 months at no charge, but you may be charged a reasonable fee if you ask for one more frequently.

To receive a copy of this Notice.

- You can ask for a paper copy of this Notice, even if you agreed to receive the Notice electronically.

To choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights.

To file a complaint if you feel your rights are violated.

- You can file a complaint by contacting the Practice and giving the following information:

-Provider Name

-Provider Title

-Provider Email

-Provider Phone Number

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- The Practice will not retaliate against you for filing a complaint.

To opt out of receiving fundraising communications.

- The Practice may contact you for fundraising efforts, but you can ask not to be contacted again.

## OUR USES AND DISCLOSURES

### 1. Routine Uses and Disclosures of PHI

The Practice is permitted under federal law to use and disclose PHI, without your written authorization, for certain routine uses and disclosures, such as those made for treatment, payment, and the operation of our business. The Practice typically uses or shares your health information in the following ways:

To treat you.

- The Practice can use and share PHI with other professionals who are treating you.
- Example: Your primary care doctor asks about your mental health treatment.

To run the health care operations.

- The Practice can use and share PHI to run the business, improve your care, and contact you.
- Example: The Practice uses PHI to send you appointment reminders if you choose.

To bill for your services.

- The Practice can use and share PHI to bill and get payment from health plans or other entities.
- Example: The Practice gives PHI to your health insurance plan so it will pay for your services. ***\*This provider does not/may not accept insurance.***

## 2. Uses and Disclosures of PHI That May Be Made Without Your Authorization or Opportunity to Object

The Practice may use or disclose PHI without your authorization or an opportunity for you to object, including:

To help with public health and safety issues

- Public health: To prevent the spread of disease, assist in product recalls, and report adverse reactions to medication.
- Required by the Secretary of Health and Human Services: We may be required to disclose your PHI to the Secretary of Health and Human Services to investigate or determine our compliance with the requirements of the final rule on Standards for Privacy of Individually Identifiable Health Information.
- Health oversight: For audits, investigations, and inspections by government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.
- Serious threat to health or safety: To prevent a serious and imminent threat.
- Abuse or Neglect: To report abuse, neglect, or domestic violence.

To comply with law, law enforcement, or other government requests

- Required by law: If required by federal, state or local law.
- Judicial and administrative proceedings: To respond to a court order, subpoena, or discovery request.
- Law enforcement: For law locate and identify you or disclose information about a victim of a crime.
- Specialized Government Functions: For military or national security concerns, including intelligence, protective services for heads of state, or your security clearance.
- National security and intelligence activities: For intelligence, counterintelligence, protection of the President, other authorized persons or foreign heads of state, for the purpose of determining your own security clearance and other national security activities authorized by law.
- Workers' Compensation: To comply with workers' compensation laws or support claims.

To comply with other requests

- Coroners and Funeral Directors: To perform their legally authorized duties.
- Organ Donation: For organ donation or transplantation.



- Research: For research that has been approved by an institutional review board.
- Inmates: The Practice created or received your PHI in the course of providing care.
- Business Associates: To organizations that perform functions, activities or services on our behalf.

### 3. Uses and Disclosures of PHI That May Be Made With Your Authorization or Opportunity to Object

Unless you object, the Practice may disclose PHI:

To your family, friends, or others if PHI directly relates to that person's involvement in your care.

If it is in your best interest because you are unable to state your preference.

### 4. Uses and Disclosures of PHI Based Upon Your Written Authorization

The Practice must obtain your written authorization to use and/or disclose PHI for the following purposes:

Marketing, sale of PHI, and treatment notes.

You may revoke your authorization, at any time, by contacting the Practice in writing, using the information above. The Practice will not use or share PHI other than as described in Notice unless you give your permission in writing.

## OUR RESPONSIBILITIES

- The Practice is required by law to maintain the privacy and security of PHI.
- The Practice is required to abide by the terms of this Notice currently in effect. Where more stringent state or federal law governs PHI, the Practice will abide by the more stringent law.
- The Practice reserves the right to amend Notice. All changes are applicable to PHI collected and maintained by the Practice. Should the Practice make changes, you may obtain a revised Notice by requesting a copy from the Practice, using the information above, or by viewing a copy at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveridentities/notice.html>.
- The Practice will inform you if PHI is compromised in a breach.

This Notice is effective at the start of your treatment date.

## Acknowledgement

My signature on this document represents that I have received the Notice of Privacy Practices and that I understand and agree to the information therein. Further, I consent to use an electronic or physical signature (patient's choice) to acknowledge the Notice of Privacy Practices.

Patient Name (Print):

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Patient Name (Sign):

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Date:

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