Form 2 PLEASE SIGN Office Policies, HIPAA, Consent for Services, Telehealth Agreement, Coordination

Office Policies My signature below indicates that I have read, understood, and agree to follow the policies established by A Child & Family Psychiatry LLC, including the policy that states I am personally responsible for fees due for services rendered regardless of insurance coverage, policies related to late cancellation of an appointment or no-show to an appointment, and what to do in case of a mental health emergency. Guardian signature(if<18)

Signature: _____

Notice of Privacy Practices I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices (HIPAA) adopted by A Child & Family Psychiatry LLC.Guardian signature(if<18)

Signature: _____

Consent for Services My signature below indicates that I give consent for clinicians and the staff of A Child & Family Psychiatry LLC to provide me with mental health treatment, which may include a psychiatric evaluation, medication management, individual therapy, couples therapy, family therapy, group therapy, play therapy, art therapy, hypnosis or any other evidence-based intervention deemed appropriate by, and within the scope of, my provider's scope of practice.Guardian signature(if<18)

Signature: _____

Telehealth Agreement If, for any reason, we are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, get immediate emergency assistance by calling 911. I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation. I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law. I understand that I am not allowed to do any recording, screenshots, etc. of any kind, of any session, and are grounds for termination of the client-therapist relationship.

Signature: _____

Coordination of Care In an effort to provide you the best care, it is important for us to be able to communicate with your primary care physician. My signature below indicates I have read, understood, and agree to give my consent to A Child and Family Psychiatry LLC, to release information, either verbal or written to the person(s) and/or agency below regarding any psychiatric/ psychological consultation or treatment I have had with A Child and Family Psychiatry LLC., including psychological testing and substance abuse information. Please provide the name of Primary Care Physician, facility name, and phone/fax number

Signature: _____

Name of Primary Care Physician, Facility Name, and Phone/Fax Number

_____

Patient Name (Guardian name if under 18) **and date**

_____

Name of person completing this form **and Date**

_____