INNOVATIVE
PSYCHIATRY

9256 Bendix Rd, Suite 200-B
Columbia, MD 21045
www.columbiapsychmd.com

Phone: 443.542.0773
Fax: 443.542.0931
admin@ecpsychiatry.com

Treatment Consent Form

Please read carefully and initial or sign where necessary

Services Offered

Individual Psychotherapy

Therapy is a unique relationship. Unlike relationships with family and friends, your relationship with your therapist will be focused on learning about and supporting you. Sometimes, people come to therapy for help coping with grief, loss, life transitions, relationship conflict, and general stress or unhappiness. Others come to therapy to learn new coping skills that they can start to use immediately to cope with feelings of anxiety or fear, while others may be more interested improving their understanding of themselves and their relationships. Typically, people seek therapy for some combination of these impulses. None of these issues are easy, and therapy can feel like hard work, especially in the beginning. People sometimes have trouble beginning therapy, or have difficulty sticking with it. Therefore, our providers encourage you to discuss these or other concerns with them, so the appointments can be most meaningful and helpful for you. With time and continued effort, many people find that attending therapy leads to increased feelings of self-worth and self-efficacy, improved ability to solve problems, and feeling better able to cope with setbacks and frustrations.

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy (DBT) is an evidence-based mode of therapy that focuses on mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance. It emphasizes the dialectical balance of acceptance *and* change, and draws on behavioral techniques to teach skills that clients can apply outside the therapy office. DBT can be helpful for many people, regardless of diagnosis, but DBT is not the right fit for everyone. It is an intensive therapy that requires a strong commitment from both client and clinician. These sessions can be challenging, and may include more education, direction, and feedback from therapist to client than other forms of therapy.

Family Psychotherapy

Family therapy is useful for family members who would like to improve their ability to communicate with one another, to resolve conflict more productively, and to cope with stressors that are affecting the entire family unit. Family therapy can be conducted with any combination of family members who are willing to attend consistently, and is typically shorter-term and focused on improving communication skills in the moment to improve a family's overall functioning.

Parent Consultation

Parent consultation sessions can be useful for parents who are looking to discuss their child's challenging behaviors, emotional upheaval, and other challenges. These one-on-one meetings with a therapist can provide new behavioral or communication strategies for parents to immediately put into place at home with their children.

For children and adolescents who are attending individual therapy, at least 1 family or parent consultation session per month is recommended.

Confidentiality

Confidentiality between a client and social worker is protected by federal and state law. Although there are some important exceptions, in general I cannot disclose any information about you without your written permission. You will be given a copy of the privacy and confidentiality statement applicable to this practice.

Fees and Payments

Please be prepared to pay at the time of your visit unless other arrangements have been made in writing. Acceptable forms of payment include cash, check and selected credit cards.

Billing rates will be discussed at or prior to your first visit.

Cancellations and No-Shows

Innovative Psychiatry, L.L.C strives to provide personalized care that is tailored to the needs of the individual. To provide such diligent care, it is imperative that patients adhere to appointment times. If there is a need to cancel or reschedule an appointment, please notify the office at least 24 hours prior to the appointment time. **Patients that fail to cancel or reschedule an appointment 24 hours prior are responsible for payment for the requested visit**. In cases as such, our billing staff will contact you to remit payment via credit card or check**.** Please note, three cancellations/no show appointments can result in termination of care.

Insurance Policies

Innovative Psychiatry, L.L.C does not currently accept insurance policies. If you are on a PPO plan, we are considered "out of network." If you wish to be reimbursed for your sessions, you will need to consult your insurance company to determine their policies regarding mental health benefits for out of network providers. We can provide you a paper bill that you can submit to your insurance company for reimbursement. However, we do not guarantee you will be reimbursed. Furthermore, you are financially responsible for sessions scheduled with Innovative Psychiatry.

Professional Records

Mental health records are standard practice in psychiatry and protected by both law and professional standards. Although you are entitled to review a copy, these records can be misinterpreted given their professional nature. In rare cases when it is deemed potentially damaging for Innovative Psychiatry to provide you with the full records, they are available to an appropriate mental health professional of your choice. Alternatively, we can review them together and/or treatment summaries can be provided. Please note that professional fees will be charged for any preparation time required to comply with such requests.

CONFIDENTIALITY

Confidentiality is a cornerstone of mental health treatment and is protected by the law. Aside from emergency situations, information can only be released about your care with your written permission. If insurance reimbursement is pursued, insurance companies also often require information about diagnosis, treatment, and other important information (as described above) as a condition of your insurance coverage. Several exceptions to confidentiality do exist that actually require disclosure by law: (1) danger to self – if there is threat to harm yourself, our providers are required to seek hospitalization for the client, or to contact family members or others who can help provide protection; (2) danger to others – if there is threat of serious bodily harm to others, our providers are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization; (3) grave disability – if due to mental illness, you are unable to meet your basic needs, such as clothing, food, and shelter, our providers may have to disclose information in order to access services to provide for your basic needs; (4) suspicion of child, elder, or dependent abuse – if there is an indication of abuse to a child, an elderly person, or a disabled person, even if it is about a party other than yourself, our providers must file a report with the appropriate state agency; (5) certain judicial proceedings – if you are involved in judicial proceedings, you have the right to prevent your physician from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require my testimony through a subpoena. Although these situations can be rare, our providers will make every effort to discuss the proceedings accordingly. Innovative Psychiatry, L.L.C also reserves the right to have a clinical consultation with supervisors or other mental health professionals for the purpose of best practices and treatment efficacy. In these circumstances, your identity will not be revealed and only important clinical information will be discussed. Please note that such consultants are also legally bound to keep this information confidential.

Contacting Providers

Our providers attempt to be accessible for all urgent issues. If they are not immediately available by office telephone, please leave a voice message and they will return your call as soon as possible. Calls are generally returned within one business day.

In situations that require immediate attention, your provider will give you their direct contact information at the first visit. You may also contact Dr. Mattai, whose emergency number is listed on our website. Please be judicious when calling after normal business hours. <u>If your call is an emergency, please contact 911 immediately instead of calling the office. Emergency psychiatric services are provided by all hospitals through their emergency rooms and do not require appointments.</u>

Email and text

Cancellations and requests to reschedule can be accommodated by phone, email, or text. Please note that I will discuss all substantive issues or concerns in person, rather than via email or text. Please also note that emails/texts should never be used for urgent or emergency issues. This is for several reasons—most importantly because email and text messages are not confidential means of communication, and we cannot ensure that messages will be received or responded to in a timely fashion.

Initials _____

Termination of Services

Many clients wonder how long treatment will take and how they will know that they are done with services. I encourage you to discuss this with me at any time during the therapy process. I will support a client's decision to terminate services under any circumstances, though I may discuss with you if I have concerns about terminating prematurely. You have the right to end services at any time. I also reserves the right to terminate services with any particular client if payment is not made in a timely fashion or if, in my clinical judgment, I come to the conclusion that therapy is unproductive or potentially harmful to the client. Terminations will always occur with recommendations for alternative treatment resources and time sufficient to connect to these resources.

Treatment Consent

Your signature below indicates that you have read the Treatment Consent Form and you agree to abide by its terms during our professional relationship.

Name of patient (print): _____

Name of legal guardian (print): _____
**(Only if patient is under 18 or a dependent adult)*

Signature: _____ Date: _____

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Authorization for Release of Information

Client's name: _____ Date of Birth: _____
Address: _____ City, State, And Zip: _____

□ I authorize Innovative Psychiatry LLC, my provider, _____ to release information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # Fax #

□ I authorize Innovative Psychiatry LLC, my provider, _____ to obtain information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # Fax #

PURPOSE OF THIS REQUEST: (check one) □ Healthcare □ Insurance □ Personal
□ Other (please describe) _____

SPECIFIC INFORMATION AUTHORIZED FOR RELEASE BY INNOVATIVE PSYCHIATRY LLC
□ Treatment History
□ Telephone Communication
□ Other (please describe): _____

MY AUTHORIZATION WILL EXPIRE:
□ When the requested information has been sent/received
□ One year from this date
□ Other (please describe): _____

I understand that:

- This authorization is voluntary and refusing to sign will not affect my ability to obtain treatment.
- I may cancel this authorization at any time by submitting a ***written*** request to Innovative Psychiatry LLC, except where a disclosure has already been made in reliance to my prior authorization

- This information that is disclosed pursuant to this authorization may be re-disclosed to by the recipients unless the recipient is covered by state or federal laws that limit the use and/or disclosure of my confidential protected health information.

_____
Date Client Signature or Signature of Parent/Guardian, if under 18

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PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:
• Protected health information may be disclosed or used for treatment, payment or health care operations
• The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
• The Practice reserves the right to change the Notice of Privacy Policies
• The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
• The patient may revoke this Consent in writing at any time and all future disclosures will then cease
• The Practice may condition treatment upon the execution of this Consent.

_____
Patient Signature (Parent or Guardian if Patient is a Minor)

_____
Relationship to Patient (If Other Than Patient):

_____
Date

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ELECTRONIC COMMUNICATION

It is impossible to guarantee the confidentially of email or text message content. By this notice you grant Innovative Psychiatry, permission to email and text message you. You acknowledge the risks and release Innovative Psychiatry from liability for the risk of your confidentiality. Our providers typically return text messages and emails within 24 hours during the week. Emails and text messages should be limited to administrative issues such as scheduling. Our providers do not accept friend requests from clients on Facebook, Linked In or other social media websites.

Please sign here that you acknowledge and agree to the above statement:

Name of Patient: _____

Signature: _____

Date: _____

*If patient is under 18 or a dependent adult

Name of Parent/guardian: _____

Signature: _____

Date: _____