10 West Madison Street #11
Baltimore, MD 21201

Complete Wellness
Complete healing for mind and body.

Phone: (443) 438-7863
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INFORMED CONSENT FOR MENTAL HEALTH SERVICES

Treatment

I understand Complete Wellness utilizes a comprehensive, multidisciplinary approach to treatment and members of my treatment team may discuss details of my treatment in order to provide me with the best treatment options. I understand my clinician only provides services for which they are competent and have been trained. My clinician may be supervised by a more experienced and licensed clinician to ensure the quality of the services provided.

Insurance and Payment Responsibility

I understand Complete Wellness will attempt to verify my insurance coverage and rates; however, it is my responsibility to contact my insurance company if I have questions about the coverage of services provided. I understand I am responsible for the payment of services not covered by insurance, **including all deductibles not paid by insurance**. Availability of services may be suspended due to an outstanding bill for services. Outstanding bills older than 90 days may be turned over to collections. I understand it is my responsibility to inform Complete Wellness of any changes in my insurance coverage and failure to do so could result in my incurring out-of-pocket expenses for services provided due to a lapse in insurance coverage. I understand using my insurance for billing purposes authorizes Complete Wellness to communicate with my insurance company to provide information necessary for billing purposes. I understand Complete Wellness utilizes a third party billing company which has access to information necessary for billing purposes.

Confidentiality

I understand that the nature of the offered mental health services have been explained to me. I also understand that the confidentiality of this service is governed by the provisions of Maryland Annotated Code, Courts and Judicial Proceedings Article, §9-109. Under these provisions, disclosure of mental health information without written authorization is permitted under certain circumstances including the following:

1. Confidentiality may not be honored if the clinical service provider has a reasonable suspicion of a client's intent to harm him/herself or another person.
2. Confidentiality may not be honored if the clinical service provider has reason to believe that there has been suspected or actual child, elderly/vulnerable adult abuse, which is not presently managed by the Department of Social Services or other appropriate agency.
3. Confidentiality may not be honored if I or my legal representative raises my mental status as a question or issue in legal proceedings. Confidentiality shall not be honored in court ordered evaluations.
4. Confidentiality may not apply to clinical supervision, case consultation, quality assurance audits, or continuity of care decisions from inpatient treatment to outpatient treatment.
5. Confidentiality may not be honored if I engage Complete Wellness or the clinical service provider in malpractice litigation or in a complaint of an ethical violation.

Medication Management

I understand that at any time while being prescribed medication, my prescribing clinician may cross reference my medical and prescription history with state databases. I understand that the prescribing clinician may request blood work to monitor health and response to medications. I understand that it is the prescribing clinician's discretion to write or revoke a prescription for a controlled substance. I understand that it is my responsibility to monitor my medication to ensure there is no lapse in available medication prior to my next medication management appointment. I understand that if I miss a scheduled appointment, it is my responsibility to notify Complete Wellness prior to a lapse in medication. I understand that requests for medication refills outside of a medication management appointment will be processed within **2 business days** of request.

Medical Records

I understand that documentation regarding my treatment is filed in an electronic health record system. I understand it is the policy of Complete Wellness to forward records only to other treating facilities or law practices with a signed release of information. Complete Wellness maintains the right to deny an individual access to his or her medical records if access to those records is determined to be potentially harmful. The process of duplicating and sending records

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requires 4 to 6 weeks. Fees for making copies are my responsibility and must be paid in advance at $0.15 per page. Medical records will only be faxed or mailed to the agency's address listed on the signed Release of Information.

Paperwork Requests

Before requesting Complete Wellness to complete paperwork for an outside agency (including but not limited to requests for emotional support animals, housing, disability, and employment), I understand that I must be a patient of Complete Wellness for at least 90 days. Completion of paperwork may only occur during a scheduled appointment with my clinician. I understand that if I have failed to appear for a scheduled appointment within the last 90 days of my request, the requested paperwork cannot be completed.

Discharge from Complete Wellness

I understand treatment is at will and I have the right to discontinue treatment at any time. I understand that if I do not attend a session within any 90-day period, I may be discharged as a patient from Complete Wellness. If I have an outstanding bill older than 90 days, I may be discharged from Complete Wellness. Discharged patients may be readmitted after 90 days.

Consent for Communication via E-Mail

If I have provided an email address, I consent to have staff of Complete Wellness communicate with me via email. I understand that email is not a confidential method of communication. I understand there is a risk that email communications between me and Complete Wellness staff and/or members of my treatment team may be intercepted by third parties or transmitted to unintended parties. I understand that any email communication between Complete Wellness staff and me, including records of my medical and psychiatric history, may be stored and made part of my medical record.

Missed Appointments

I understand that in order for treatment to be successful I must commit to regular attendance for both psychotherapy and medication management appointments. If I need to cancel an appointment, I will contact Complete Wellness *at least* **2 business days** prior to my scheduled appointment time. If I do not provide adequate notice, the visit will be counted as a missed appointment and I will be responsible for the **$50 missed appointment fee**. This fee must be paid before attending any future appointments. **For psychological testing, the missed appointment fee is $250**.

I understand if I miss **2 consecutive appointments**, without prior notification, my case will be closed and there will be a 90-day waiting period before readmission.

Annual Administrative Fee

I understand I will be charged a yearly administrative fee of **$30.00**. I understand that this will be collected at my first appointment **after March 31, 2019.**

My signature below indicates I have been informed and understand the limits of confidentiality, I accept the conditions of the professional relationship set forth in this document. I consent to psychological treatment, and I agree to remit the financial balance for services rendered.

Client Name (Print)_____

Client Signature _____ Date _____

Authorized Representative _____ Date _____

Office Use Only:

❑ Informed Consent ❑ Confidentiality ❑ Refill Requests ❑ Cancellations/Missed Appointments

Clinician _____ Date _____

Clinical Supervisor_____ Date _____