Consent for Treatment

To be completed by the Patient or Conservator

Name of Patient: _____

Birth Date: _____

Gender of Patient: ☐Male ☐Female ☐ Non-Binary

If the patient is conserved please list the below information.

Name of Consenting Adult:_____

Address: _____

Phone Number: _____

- I hereby consent to diagnosis and treatment by authorized representatives of North American Mental Health Services (NAMHS).
- I understand that the care provided may include medication management and therapy, as well as other services found necessary in the professional judgment of the treating providers.
- I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my condition.
- I certify that I have the authority to consent to treatment on behalf of the patient named above.
- I understand that this authorization will remain in effect for one year from the date signed.
- I acknowledge that I am responsible for all reasonable charges in connection with the care and treatment rendered during this period.

I have read and understood this form, and give my consent to NAHMS to treat.

_____ _____

Signature of Consenting Adult Today's Date

NORTH AMERICAN MENTAL HEALTH SERVICES

Adult Form

PLEASE COMPLETE ALL INFORMATION FULLY (please print)

Date:_____

Last _____ First_____ MI_____

Pronoun: ☐ He/Him ☐She/Her ☐They/Them/ Their ☐ Other: _____

Birth Date _____ Age _____ SSN _____ Ethnicity _____

Gender: ☐ Female ☐ Male ☐ Non-Binary ☐ N/A Marital Status _____

Primary Phone Number _____ Secondary Number _____

Home Address _____

Mailing Address _____

Spoken Language _____ Is a Translator Required ☐ Yes ☐ No

Does the patient have any cultural needs? If so please list:_____

Emergency Contact Name _____ Phone Number _____

☐ By checking this box you are consenting to allow North American Mental Health Services to contact the above person in case of an emergency. Personal health information will only be provided on an emergency basis. This does not allow the person to contact our office and inquire about personal mental health information about you. If you would like anyone to have access to your records, please ask for a release of information form.

Whom may we thank for your referral? _____ __

Are you a Simpson University Student? ☐ Yes ☐ No

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Student

GUARANTOR INFORMATION

Last First MI

_____ _____ _____

Primary Phone Number _____ Spoken Language _____

Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian/Conservator

INSURANCE INFORMATION

Primary Insurance Company _____

Subscribers Name (as it appears on the card) _____

Subscribers ID # _____ DOB _____ SSN _____

Secondary Insurance Company _____

Subscribers Name (as it appears on the card) _____

_____ _____ _____

Subscribers ID # DOB SSN

MENTAL HEALTH INFORMATION

Your Symptoms: (Please check all that apply)

☐ Anger ☐ Sedated Feeling ☐ Drug/Alcohol Dependency ☐ Sad ☐ Flashbacks ☐ Overwhelmed

☐ Trauma ☐ Euphoric ☐ Appetite Change ☐ Fatigue ☐ Compulsive ☐ Mood Changes ☐ Worry

☐ Hopeless ☐ Poor Concentration ☐ Poor Job/School Performance ☐ Sense of Superiority

☐ Unable to Focus ☐ Hallucinations ☐ Self-Harm ☐ Isolating ☐ Distracted Easily

☐ Lack of Interest in Activities

Your Thoughts: (Please check all that apply)

☐ Scattered ☐ Racing ☐ Negative ☐ Suicidal ☐ Obsessive

Sleep Changes: ☐ Too Much ☐ Too Little ☐ Nightmares

Please list any other symptoms you experience that are not listed above: _____

_____

PERSONAL MEDICAL PROBLEMS

☐ High Blood Pressure ☐ Diabetes ☐ Stroke ☐ Head-Injury ☐ Kidney Disease

☐ Liver Disease ☐ Heart Disease ☐ Lung Disease ☐ Dementia ☐ Glaucoma

☐ Parkinson's Disease ☐ Visual Impairments ☐ Hearing Impairment

Other:_____

CURRENT MEDICATIONS

Medications: (List all medications you are taking regularly. Include all prescription and non-prescription)

Are you allergic to any medications? ☐ Yes ☐ No Please list: _____

_____

NAME	DOSAGE	FREQUENCY

Are you allergic to any medications? ☐ Yes ☐ No Please list: _____

FAMILY MENTAL HEALTH HISTORY

Please check all that apply regarding your family history:

☐ Bi-polar ☐ Anxiety ☐ Suicide ☐ Mental hospitalization ☐ Obsessive-Compulsive

☐ Depression ☐ Schizoprenia ☐ Drug/Alcohol Abuse ☐ PTSD ☐ Eating Disorders ☐ Autism

☐ Other:_____

SOCIAL HISTORY INFORMATION

Do you smoke, vape, or chew tobacco? ☐ Yes ☐ No If yes, how much per day?_____

Do you drink caffeine? ☐ Yes ☐ No If yes, how many cups per day? _____

Do you consume alcohol? ☐ Yes ☐ No If yes, how many drinks per day? _____

Do you have a history of recreational drug use? ☐ Yes ☐ No

If yes, please list:

Do you use Medical Marijuana? ☐ Yes ☐ No

Do you have your 215 card? ☐ Yes ☐ No (if yes, please provide a copy)

Have you ever been prescribed a controlled substance? ☐ Yes ☐ No

Substance	How often used	How long	How used	Last used

Are you currently being treated for suboxone? ☐ Yes ☐ No List treating physician: _____

Have you ever been treated for substance abuse? ☐ Yes ☐ No If yes, please describe when, where, and how long treatment was: _____

_____

Do you have a history of domestic violence? ☐ Yes ☐ No If yes, please explain: _____

_____

What is the reason for your visit today? ☐Work ☐Home ☐Family ☐School

QUESTIONS FOR THOSE BORN BIOLOGICALLY FEMALE

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No

Are you taking oral contraceptive? ☐ Yes ☐ No Are you nursing ☐ Yes ☐ No

Are you trying to become pregnant or hope to be in the next 6 months to 1 year? ☐ Yes ☐ No

CONTROLLED SUBSTANCE AGREEMENT

Controlled substance medications (i.e., benzodiazepines, sedatives, stimulants, etc.) are Very useful, but have potential for misuse; therefore, they are controlled by local, state, and federal government. They are intended to improve function and/or ability to work, not simply to feel good. The purpose of this agreement is to prevent misunderstandings about certain medications you may be prescribed for the management of certain conditions.

- I, _____, understand and voluntarily agree that

(Initial each statement after reviewing):

- I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.
- I will inform my provider of any current or past substance abuse, or any current or past substance abuse of any immediate family member.
- I will not request or accept controlled substance medication form any other physician or individual while being prescribed such medication from Native American Mental Health Services or North American Mental Health Services (NAMHS) provider(s). Besides being illegal to do so, it may endanger my health. The only exception is upon admittance to a hospital.
- I agree to use one pharmacy for my medications. My pharmacy is_____ located at _____ with telephone number _____.
- I will tell the provider all medications that I may take. I will supply prescriptions in original bottles if requested by the provider. I will also inform the provider of any new medical conditions, new medications, and of any adverse effects I may experience from any of the medications I take or have taken in the past.
- I will inform my other health care providers that I am obtaining controlled medications from my provider at NAMHS.
- I understand I am responsible for my controlled medications. It is my responsibility to monitor the amount remaining in my prescription. It is my responsibility to keep my medications away from children.
- I understand that if my medication is lost, stolen, misplaced, or used sooner than prescribed my provider may not refill or replace the medication. If my medication is stolen I will need to provide a copy of the filed police report to my provider.
- I will not allow anyone else to have, use, sell, or in any way have access to these medications. Sharing medications with anyone is against the law.
- I understand the importance of following my treatment plan as directed by my provider.
- I will cooperate with unannounced urine or blood toxicology screenings, as well an any random pill counts of medication if requested by my provider. Failure to comply will be considered a positive toxicology result.
- I understand that the presence of unauthorized and/or illegal substances in the toxicology screenings may result in treatment being stopped and possibly being discharged as a patient.
- I understand that I will take my medication as instructed and prescribed, and I will not exceed the maximum dosage prescribed. Any change in dosage must be approved by my provider.
- I understand that tampering with a written prescription is a felony and I will not change or tamper with my providers' written prescription. I am also aware that attempting to obtain a controlled substance under false pretenses is illegal.

CONTROLLED SUBSTANCE AGREEMENT CONTINUED

- I agree to keep my scheduled appointments. If I must cancel my appointments I will do so in no less than 24 hours prior to my appointment. I must have and keep appointments for refills to be approved.
- I understand that refill requests for **ALL** medications must be made at least 72 hours in advance. Refill requests will not be addressed after office hours, on holidays, or on weekends. No early refills will be given unless my provider authorizes the refill (i.e. provider or patient going out of town).
- I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by the checking the Prescription Monitoring Program web site periodically throughout my treatment period.
- I understand that this agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this agreement.
- I understand that if I break this agreement, my provider will stop prescribing controlled substances and I may be discharged as a patient.

I have read this agreement and fully understand its contents. In addition, I fully understand the consequences of violating this contract.

Pharmacy Name:_____ **Phone Number:**_____

Pharmacy Location:_____

Patient Name (please print): _____ **Date:** _____

Signature of Patient or Patient's Legal Representative:_____

Print Name of Legal Representative (if applicable):_____

PRESCRIPTION REFILL POLICY

North American Mental Health services value our patients and strive to provide the best patient care possible. In order to get prescription refills sent to the pharmacy in a timely manner we ask that you do the following:

- Call your pharmacy and have them fax a refill request to NAMHS at (530) 275-2201
- This needs to be done **ONE WEEK PRIOR TO WHEN YOU ARE DUE FOR A REFILL.**

This does not include medications that require a triplicate. In order to get a triplicate prescription refilled you must do the following:

- Call our clinic at (530) 646-7269 and notify the staff of your request **ONE WEEK PRIOR TO WHEN YOU ARE DUE FOR A REFILL.**

You are responsible for making sure the pharmacy has the correct fax number AND that you give the pharmacy staff and NAMHS staff enough time in advance to get the refill approved and filled before you run out of your medication. As a courtesy to NAMHS staff and to make the process go faster we ask that you choose one pharmacy for all your medications.

Please sign below stating you understand and you will comply with this policy.

Patient Name (please print): _____ **Date:** _____

Signature of Patient or Patient's Legal Representative:_____

Print Name of Legal Representative (if applicable):_____

Informed Consent, Disclosure Statement & Agreement for Therapy Services

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information about Your Therapist

Therapists in this office are skilled and qualified clinicians with a varied range of experiences, training and skills. Feel free to discuss any questions you have about this with your therapist at any time. It is our goal to provide you with quality care and service.

Fees and Policies

Individual sessions and conjoint (marital /family) sessions are approximately 25 minutes in length unless otherwise determined.

Confidentiality

All communications between you and all therapists in this office will be held in strict confidence unless you provide written permission to release information about your treatment.

If you participate in therapy, no confidential information about your treatment will be disclosed unless all person(s) who participated in the treatment with you provide their written authorization to release such information. However, it is important that you know that therapists in this office utilize a "no-secrets" policy when conducting family or marital/couples' therapy. This means that if you participate in family, and/or marital/couples' therapy, we are permitted to use information obtained in an individual session that you may have had with your therapist, when working with other members of your family. Please feel free to ask your therapist about this "no secrets" policy and how it may apply to you with your therapist. As part of a treatment team with your medical provider, there may be a time where consultation will be beneficial to you. Therefore, for the benefit of your treatment, discussion may take place between your medical provider and the therapist. These consultations will also be held in strict confidence. There are exceptions to confidentiality.

- All therapists are mandated reporters in the state of California, meaning they are required to
- report instances of suspected child, elder, or dependent adult abuse.
- Furthermore, they are required to break confidentiality if it is determined that you present a serious danger of physical violence to another person and the person must be warned.
- Additionally, we have an ethical duty to protect you if it is believed that you present a danger to yourself, and your therapist may break confidentiality to do this.

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, in the exercise of appropriate professional judgment, your therapist may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with the clinician.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. You or your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. To cancel or reschedule an appointment, you are expected to notify our office at least 24 hours before your appointment.

Therapist Availability/Emergencies

You may leave a message at any time on our office's confidential voicemail at (530) 646-7269. If you wish for someone to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours.

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

About the Therapy Process

It is our intention to provide services that will assist you in reaching your goals. Based upon the information that you provide, and the specifics of your situation, we will provide recommendations to you regarding your treatment. We believe therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with any recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each patient, we are unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. We will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determine that you are not benefiting from treatment, either may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask your therapist to address any questions or concerns that you have about this information before you sign.

*Patient Name (please print)*_____ *Patient Signature*_____

*Date*_____

Guardian Signature _____ *Date*_____

Patient copy provided ☐

CONSENT FOR RELEASE OF INFORMATION WITH PRIMARY CARE DOCTOR

Authorization for Behavioral Health and Primary Care Physician to Share Confidential Information

I _____, ☐ **Consent** ☐ **Do Not Consent** to give permission to North American Mental Health Services and my Primary Care Physician to share information about my diagnosis and/or treatment related substance abuse, mental health, or medical history, NOT including the results of a blood test for antibodies to the human immunodeficiency virus (HIV).

I understand the purpose of sharing information is to help me receive better care.

I further understand that my refusal to share information does not effect my insurance coverage and it will not affect my ability to obtain treatment at North American Mental Health Services.

Finally, I understand that **I may revoke this authorization,** at any time, provided that I do so in writing. Unless revoked earlier, this consent form expires 1 year from the date of signing.

Primary Care Physician's Name: _____

Primary Care Physician's Phone Number: _____

Patient Name (please print): _____ **Date:** _____

Signature of Patient or Patient's Legal Representative:_____

Print Name of Legal Representative (if applicable):_____

CONSENT FOR RELEASE OF INFORMATION WITH PREVIOUS MENTAL HEALTH PROVIDER

Authorization for NAMHS and Previous Mental Health Provider to Share Confidential Information

I _____, ☐ **Consent** ☐ **Do Not Consent** to give permission to North American Mental Health Services and my Previous Mental Health Provider to share information about my diagnosis and/or treatment related substance abuse, mental health, or medical history, NOT including the results of a blood test for antibodies to the human immunodeficiency virus (HIV).

I understand the purpose of sharing information is to help me receive better care.

I further understand that my refusal to share information does not effect my insurance coverage and it will not affect my ability to obtain treatment at North American Mental Health

Services.

Finally, I understand that **I may revoke this authorization,** at any time, provided that I do so in writing. Unless revoked earlier, this consent form expires 1 year from the date of signing.

Previous Mental Health Providers Name: _____

Previous Mental Health Providers Phone Number: _____

Patient Name (please print): _____ **Date:** _____

Signature of Patient or Patient's Legal Representative:_____

Print Name of Legal Representative (if applicable):_____

NO SHOW POLICY

Please note that medication management and therapy are two separate services provided by NAMHS and are managed separately.

North American Mental Health Services defines a "no-show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment.
- Cancels with less than 5-hour notice.
- Cancelation of 2 or more consecutive therapy appointments.
- Arrives more than 5 minutes late and is consequently unable to be seen.

How to avoid getting a No-Show:

- Confirm your appointment the day before your appointment is scheduled through the appointment reminders.
- Arrive **15 minutes early for follow up appointments and 30 minutes early for new patient appointments** for your scheduled appointment.
- Give at least **24 Hour** notice to cancel the appointment. Please note that two cancelled therapy appointment in a row is equal to one no show.

Appointment Confirmation:

North American Mental Health Services will send out an automated confirmation appointment reminders the day before the scheduled appointment. If the clinic does not confirm this appointment with the patient, then the patient needs to call back to confirm their appointment the day before the scheduled appointment.

Consequences of a No-Show:

- After a patient's **FIRST** no-show, the clinic will issue a verbal warning by calling the patient and informing the patient that they have missed their appointment.
- After a patient's **SECOND** no-show, the clinic will issue a written warning that will be mailed to the patient's mailing address on file.
- After a patient's **THIRD** no-show, the clinic will issue a suspension letter that will be mailed to the patient's mailing address on file. The patient will not be scheduled for 6 months after the date of the letter.

If you have missed 2 or more appointments in a row due to no-shows or cancelations, you may be removed from reoccurring appointments.

Please sign below stating you understand and you will comply with this policy.

Patient Name (please print): _____ **Date:** _____

Signature of Patient or Patient's Legal Representative:_____

Print Name of Legal Representative (if applicable):_____

Patient Health Questionnaire (PHQ-9)

Name: _____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use a ✓ to indicate you answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy	**0**	**1**	**2**	**3**
5. Poor appetite or overeating	**0**	**1**	**2**	**3**
6. Feeling bad about yourself or that you area fail-ure or have let yourself or your family down	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching TV	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
9. Thoughts that you would be better off dead, or of hurting yourself	**0**	**1**	**2**	**3**
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)	**Add columns**	**+**	**+**	
	TOTAL:			

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

North American Mental Health Services

Your Information. Your Rights. Our Responsibilities.

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

• Address workers' compensation, law enforcement, and other government requests

• Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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 and make choices about your health information.

• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting us using the information on page 1.

• 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/.

• We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in your care

• Share information in a disaster relief situation

• Include your information in a hospital directory If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

• Marketing purposes

• Sale of your information

• Most sharing of psychotherapy notes

In the case of fundraising:

• We may contact you for fundraising efforts, but you can tell us not to contact you again.

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

• We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

• We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

• We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety

Do research

• We can use or share your information for health research.

Comply with the law

• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

• We can share health information with a coroner, medical examiner, or funeral director when an individual die.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.

• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

• We must follow the duties and privacy practices described in this notice and give you a copy of it.

• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective 12/14/2020

This Notice of Privacy Practices applies to the following organizations. Effective 08/14/2017 This notice applies to any entity doing business as Native/North American Mental Health Services.

Patients Full Name (Please Print) _____ Signature _____

Guardian's Full Name (Please Print) _____ Signature _____

For any questions or concerns please contact Amy Coffman - HIPPA Compliance Officer.

Informed Consent for Telehealth Services

Telehealth involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care and mental health services and therapy. Telehealth services offered by North American Mental Health Services ("Group") may also include chart review, remote prescribing, prescription refills, appointment scheduling, health information sharing, and non- clinical services, such as patient education. The information you provide may be used for diagnosis, therapy, follow-up and/or patient education, and may include any combination of the following: (1) health records and test results; (2) images; (3) live two-way audio and video; (4) interactive audio and messaging; and (5) output data from medical devices and sound and video files.

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Telehealth services from our Group physicians and mental health professionals (e.g., nurse practitioners, physician assistants, independent marriage and family therapists, licensed marriage and family therapists, psychologists, psychologist interns, psychologist assistants, social workers, social worker interns, registered nurses, and case workers) (collectively, our "providers") are an addition to, and not a replacement for, your in-person contact with your primary care doctor, who may be a provider with our Group.

Expected Benefits:

- Improved access to care by enabling you to remain in your home while the Group provider consults and obtains test results at distant/other sites.
- More efficient care evaluation and management.

Obtaining expertise of a specialist as appropriate.

Possible Risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies.
- In rare events, our provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person consult.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.

In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By signing below, you acknowledge that you understand and agree with the following:

1. I hereby consent to receiving Group's services via telehealth technologies. I understand that Group and its providers offer telehealth-based medical services. I also understand it is up to the Group provider to determine whether or not my specific clinical needs are appropriate for a telehealth encounter.

2. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Group will take steps to make sure that my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners who may be located in other areas, including out of state.
3. I understand there is a risk of technical failures during the telehealth encounter beyond the control of Group. I agree to hold harmless Group for delays in evaluation or for information lost due to such technical failures.
4. 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, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1- 1 immediately and that the Group providers are not able to directly connect me to local emergency services. North American Mental Health Services Informed Consent for Telehealth Services 4834-2675- 2570.
5. I understand that alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the services involving tests may be conducted by individuals at my location, or at a testing facility, at the direction of the Group provider (e.g. labs or bloodwork).
6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Persons may be present during the consultation other than the Group provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non- medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.
8. I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.
9. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records which will be provided to me at reasonable cost of preparation, shipping and delivery.

Patient Consent

I have read this document carefully, and understand the risks and benefits of the telehealth consultation and have had my questions regarding the procedure explained and I hereby give my informed consent to participate in a telehealth consultation under the terms described herein.
I hereby state that I have read, understood, and agree to the terms of this document.

PATIENT'S SIGNATURE*

_____

If patient is a minor, lacks capacity to provide informed consent for medical treatment or otherwise requires a legal guardian*' to authorize telehealth services, the legal guardian's signature is required:

AS LEGAL GUARDIAN OF

_____

I CONSENT TO THE ABOVE TERMS AND CONDITIONS

GUARDIAN'S RELATIONSHIP TO PATIENT

_____

GUARDIAN'S SIGNATURE

_____

* A legal guardian is a person who has the legal authority (and the corresponding duty) to care for the personal and property interests of another person, called a ward. Guardians are typically used in three situations: guardianship for an incapacitated senior (due to old age or infirmity), guardianship for a minor, and guardianship for developmentally disabled adults.