Philadelphia Integrative Psychiatry
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Consent for Treatment; Consent to Use and Disclosure of Health Information; Clinical Policies and Procedures; Consent to Electronic Communications; and Acknowledgement of Receipt of Notice of Privacy Practices

Welcome to DMD Endeavors LLC, d.b.a. Philadelphia Integrative Psychiatry (the "Practice", "we", "us" or "our"). You must review and complete this form before the Practice can provide professional services.

CONSENT FOR TREATMENT:

The individual signing this form ("You") hereby consents as or on behalf of the patient named above (the "Patient") to permit the Practice through its psychiatrist(s), psychologist(s), physician assistant(s), counselor(s), nurse practitioner(s), nurse(s), and other staff to provide diagnostic and other behavioral health care and treatment to the Patient that is medically reasonable and necessary in the professional judgment of the Practice's professional staff, which may include, among other things, receiving and participating in psychiatric evaluations, individual/group/family psychotherapy, pharmacotherapy, and/or crisis intervention. Further, You consent for the Patient to receive a comprehensive diagnostic assessment, after which You, the Patient, and the Practice will mutually determine whether to continue treatment.

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION:

You hereby consent to the Practice's use and disclosure of medical information in Practice's possession concerning the Patient's behavioral health treatment that may identify You and/or the Patient and be considered "protected health information" to: a) the Practice's workforce, including employees, contractors, trainees, and volunteers, and any other health care provider involved in the Patient's care for purposes of providing treatment to the Patient; b) the Practice's workforce and other permitted parties for purposes of the Practice's health care operations; and c) any other permitted purpose for which the Practice is not required to obtain a separate, express authorization, as permitted or required by applicable state and federal laws and regulations.

CLINICAL POLICIES AND PROCEDURES

Telephone Communications: To safeguard the Patient's protected health information, the Practice will only leave messages regarding the Patient's medical and billing information at the phone number(s) on record, your patient portal, through the Spruce text or App, and/or your email address on record. When leaving a message or speaking with another person regarding the Patient's care, the Practice will limit the information disclosed to the minimum that is necessary.

This consent is not valid to permit use or disclosure of the Patient's protected health information for a purpose that requires an authorization under the HIPAA Privacy Rule (45 CFR § 164.508), or where other requirements or conditions exist for the use or disclosure of the Patient's protected health information under state laws and regulations.

Telepsychiatry: Telepsychiatry includes both video and telephone interactions during which psychiatric and/or therapeutic care are discussed (so this consent holds for both psychiatric & therapy appointments). Telepsychiatry provides psychiatric & therapy services using HIPAA compliant interactive video conferencing tools in which the psychiatrist/therapist and the patient are not at the same location. Telephone calls without video may be used for cases when video is not viable or preferred, and in-person sessions are not feasible. Telepsychiatry will allow the patient to receive psychiatric and therapeutic care without the need to visit the office and travel long distances.

- Your rights with regards to telepsychiatry:
    - The laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry;
    - The various forms of telepsychiatry we employ are known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

    - You have the right to withdraw your consent to the use of telepsychiatry during the course of your care at any time.
    - Philadelphia Integrative Psychiatry has the right to withhold or withdraw consent for the use of telepsychiatry during the course of your care at any time;
- Potential risks include, but may not be limited to:
    - Information transmitted may not be sufficient (poor resolution of video);
    - Delays in medical evaluation and treatment due to deficiencies or failures of the equipment;
    - Security protocols can fail, causing a breach of privacy; and
    - A lack of access to all the information available in a face to face visit may result in errors in medical judgment.
- Alternatives to telepsychiatry include traditional face to face sessions.
- Patient's Responsibilities
    - You will not record any telepsychiatry sessions without written consent from us. Similarly, we will not record any of our telepsychiatry sessions without your written consent.
    - You will inform your provider if any other person can hear or see any part of our session before the session begins. Similarly, the provider will inform you if any other person can hear or see any part of your session before the session begins.
    - You, not your provider, are responsible for the configuration of any electronic equipment used on your computer or phone that is used for telepsychiatry. You understand that it is your responsibility to ensure the proper functioning of all electronic equipment before your session begins.

Emergencies: The Practice is not available after hours or on holidays & weekends and is not considered an emergency resource. If there is a potential of any physical danger to You, the Patient, or others, You shall call 9-1-1 immediately, go to the nearest emergency room, or call a crisis hotline (such as the National Suicide Hotline at 800-784-2433). After the Patient receives emergency attention, You shall contact the Practice as soon as is feasible at 610-999-6414.

Collaboration with other Healthcare Practitioners: It is essential for the Practice to communicate and share records with the Patient's current and recent healthcare providers. This is to help establish a more accurate diagnosis, provide therapeutic collaborative care, foster effective coverage in a provider's absence, and decrease the chance for medication errors. Such practitioners include, but are not limited to, inpatient psychiatric practitioners, covering practitioners, primary care physicians, current therapists, any other mental health practitioners the Patient may have seen within the past year, and the Patient's pharmacists. By signing this form, you consent to allow the Practice and its practitioners to disclose and share your medical information for purposes of treatment and coordination of care. The Practice requires access to the Patient's prescription history over the past year to decrease the chance for double prescribing and other prescribing errors (there is nothing to do on Your end in this regard).

Medication Management: If the Patient is receiving medication management with our staff, we require visits at a minimum of every three months. If the Patient is not willing to be seen at the frequency the staff feels is necessary for the Patient's safety and mental health stability, then the Practice reserves the right to terminate the treatment relationship and assist in the transition of the Patient's care to an appropriate medical professional.

Medication Refills: It is Your responsibility to contact the Practice if the Patient needs additional medication before the Patient's next visit. The Practice will only refill medication if the Patient is active in treatment. The Practice may refuse to give a refill if the Practice has not seen the Patient recently and the Practice feels that an office appointment is clinically indicated. Please allow up to three business days to process refill requests. Refills are not processed over weekends or holidays. If prior authorization is required, it is the Patient's responsibility (not the pharmacy's) to get in touch with the Practice. The Practice requires five business days to attempt to get authorization (most of the time it is in the insurance company's hands as to how quickly this can be processed). The practice charges an administrative fee for prior authorizations at a rate of $30/hour, broken down into 15 minute increments.

Coverage: If the Patient's scheduled psychopharm provider is unavailable, the Practice will provide appropriate coverage by a psychiatrist, nurse practitioner, or physician assistant. Please see the "Emergencies" section, above, related to

emergencies occurring outside of the Practice's business hours, which are currently Monday through Friday, 9:00 a.m. to 5:30 p.m., but are subject to change.

Minor Patient Caretaker: You are the legal guardian of the Patient, a minor child who under the age of 14 is unable to consent for their own mental health treatment under Pennsylvania law, and You designate and authorize a caretaker to bring the minor Patient to the Practice for scheduled appointments for behavioral health care and treatment in which You previously consented be provided to the minor Patient. You understand that only a legal guardian may consent to treatment for the minor Patient, by signing this contract.

Commitment: Pennsylvania law gives mental health practitioners, including the Practice and certain of its professional staff, the right to commit the Patient to an inpatient psychiatric unit if the mental health practitioner believes that the Patient is a danger to themselves or others, even if the Patient and/or You disagrees.

Mandated Reporter: As healthcare providers, the Practice is required, by law, to make a report of suspected child abuse if they have reasonable cause to suspect that a child is a victim of child abuse. It is not required that the child come before the mandated reporter in order to make a report of suspected child abuse nor are they required to identify the person responsible for the child abuse to make a report of suspected child abuse.

Forensic Services and Disability Determinations: The Practice does not provide forensic services such as custody evaluations, assessments recommended by probation, ability to stand trial, etc.

Benzodiazepine Policy: As a general rule, the Practice avoids prescribing benzodiazepines, as they have been shown to potentially increase the risk of Alzheimer's, can be addictive, and can reinforce anxiety. Potential exceptions to this general rule include prescriptions for detox purposes, very infrequent use (*e.g.*, once per month for fear of flying), and other rare circumstances.

Recordings: Audio and/or video recording by You and/or the Patient of any session at the Practice is prohibited. If an unauthorized recording is made, it is grounds for the Practice to terminate the treatment relationship.

Discontinuation of Treatment: The Practice may discontinue treatment with the Patient only after a reasonable amount of discussion and usually for one of the following reasons: (1) Canceling/missing appointments too often; (2) Non-compliance with treatment recommendations; and (3) Other reasons include inappropriate/unprofessional behavior, concerns regarding safety, misuse of medication, or lack of compliance with treatment or payment. Additionally, unless otherwise notified by You or the Patient, the Practice will assume that the Patient's treatment relationship with the Practice has terminated ninety days after the Patient's last visit unless the Patient has an appointment scheduled for a future date. Additionally, the Patient is considered terminated from treatment when clients come for an initial consultation and it is determined no medication management or ongoing psychiatric care is warranted. Upon termination of the treatment relationship, the Practice carries no further responsibility for the Patient's care. The Patient may re-enter treatment with the Practice at the Practice's discretion and, upon reentering, will be held to the initial signed Consents and, at the Practice's discretion, will be expected to go through either a 50 minute follow up appointment or a a new inpatient intake appointment, and pay those relevant fees.

CONSENT TO ELECTRONIC COMMUNICATION

Email & Text Communications: We attempt to make communication with our clinicians as easy and efficient as possible, which is why we employ SMS text, email, and app based communication. Based on this consent, the Practice shall use electronic communications, including email, SMS text messages, phone applications, and phone calls to communicate with You and the Patient including with regard to protected health information. This consent provides You with information about how we use these types of communications and the associated risks. It will also be used to document Your consent to use these types of electronic communications to communicate with You, the Patient, or others You may designate above. You hereby agree to create an account or otherwise sign up with such vendor, at no cost to You or the Patient, in order to receive and send electronic messages (text, email, and application based messaging) and receive phone calls. However, text & email or, by nature, not completely secure. We therefore ask for the Patient's consent to employ email or standard SMS messaging regarding various aspects of the Patient's medical care, which may include, but shall not be limited to, test results, prescriptions, medication ideas, side effects, appointments, and billing. The patient

understands that email and standard SMS messaging are not confidential methods of communication and may be insecure. The patient further understands that, because of this, there is a risk that email and standard SMS messaging regarding their medical care might be intercepted and read by a third party.

You will have the same access rights to this portion of the Patient's medical record as You do to the rest of the Patient's record, as described in the Practice's Notice of Privacy Practices. The Practice may forward electronic communications among the Practice's staff for purposes of the Patient's diagnosis, treatment, or other permitted purposes. When the Practice collaborates with Your other health care practitioners, the Practice will either use a fax or password protected documents when emailing Your protected health information. Please review the Notice of Privacy Practices for information about permitted uses of the Patient's protected health information and Your rights regarding the confidentiality of this information.

Risks: Electronic communications, including SMS text messages, emails, and voicemails can be forwarded, circulated, stored electronically, or broadcast to many intended or unintended recipients. Electronic communications and voicemails can be forwarded to other recipients, altered, or intercepted without the original sender's permission or knowledge. Electronic communications can be easily misaddressed. Backup copies of electronic communications often exist, even after the sender and/or recipient has deleted the original version. Employees do not have an expectation of privacy at their place of employment, and employers and online services can inspect the communications sent through their company systems. We recommend that You and the Patient do not use an employer's email system or employer-issued electronic devices to send or receive confidential medical information. Electronic communications may not always be secure, so it is possible that a third party may breach the confidentiality of these communications. Although the Practice will use reasonable and appropriate means to protect the security of the Patient's protected health information, it cannot guarantee the security and confidentiality of electronic communications.

Your Responsibilities. If You provide Your consent to use of electronic communications, it is Your responsibility to do the following. Call 9-1-1 if the Patient is experiencing a medical emergency – do not use electronic communications with the Practice in this situation. Inform the Practice's staff of any specific information You do not want communicated via electronic communications. Protect passwords or other means of accessing the electronic communications sent by or to You or the Patient related to the Practice. Follow up with the Practice if You have not received a response to Your or the Patient's electronic communication within two business days, to determine whether the intended recipient has received it and to inquire about an expected response time. Notify us immediately of any changes to Your preferred mobile telephone number or email address.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

You hereby confirm that the Patient has been provided with a copy of the Practice's current Notice of Privacy Practices before signing this document (the first of the 3 agreements in this group of files, which you initialed above). The Notice of Privacy Practices describes the types of uses and disclosures of the Patient's protected health information that will occur for the Patient's treatment, payment of my bills or in the performance of healthcare operations of the Practice and the Practice's duties regarding the Patient's protected health information. The Notice of Privacy Practices also describes the Patient's rights with respect to the Patient's protected health information and how the Patient may exercise these rights. The Practice reserves the right to change the practices described in the Notice of Privacy Practices. The Patient may obtain a revised Notice of Privacy Practices by calling Practice's office and requesting a revised copy. By signing below, You acknowledge receipt of the Notice (on behalf of the Patient, as applicable).

I HAVE READ AND I UNDERSTAND AND ACCEPT THE TERMS AND CONDITIONS OF THE CONSENTS, POLICIES, PROCEDURES, AND DISCLOSURES SET FORTH ABOVE.

_____ _____

Print Name of Patient **Date**

_____

Signature of Patient or Responsible Party

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Relationship of Responsible Party to Patient (Self, Parent, etc.)