SYNAPSE
INTEGRATED PSYCHOLOGY

PATIENT CONSENT FOR TREATMENT

*Patient Name:*_____ *Patient Date of Birth:*_____

CONSENT TO MEDICAL CARE AND TREATMENT

I am being treated at Synapse Integrated Psychology (SIP), a private healthcare facility in compliance with state and federal laws. I understand that if I misrepresent my condition or do not follow my provider's recommendations as they may relate to my health that the provider and this office will not be responsible for any injuries or damages that are a result of my non-compliance. I understand there are no guarantees concerning the results of my care.

I understand that if I am getting medication management, I must allow at least 48 hours for prescription refills to be processed. I understand that urine drug screens are a common and accepted practice for behavioral health providers, and I may be asked to provide a urine sample without warning if I participate in substance abuse treatment, court-ordered treatment or I am prescribed controlled substances. I consent to this policy and I understand that failure or refusal to provide urine drug screen may impact my treatment at this practice.

CONSENT TO USE OF INFORMATION

Electronic Health Records: I understand that Synapse Integrated Psychology may collaborate with other health care providers to coordinate, manage and provide health care to me and I consent to the SIP sharing my health information and records electronically for the purpose of treatment, payment and/or operations, including the overall quality health care services provided to me (e.g., avoiding unnecessary or duplicate testing, etc.). I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The electronic health record (EHR) will be accessible by Synapse Integrated Psychology credentialed providers as well as other individuals approved to access the EHR for purposes related to treatment, payment, health care operations and or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act ("HIPAA"). Synapse Integrated Psychology has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPAA.

Use and Disclosure of Information: In addition to the above consent to use and share my health information with the Synapse Integrated Psychology EHR system, I agree that the Synapse Integrated Psychology may use and disclose my health information for a range of purposes including: treatment, eligibility verification, and/or payment to private and public payers or their agents including insurance companies, managed care organizations, obtaining pre-authorization, quality of care assessment and improvement activities, evaluating the performance of qualifications of physicians and health care workers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements and public health oversight services.

Request for Information from Others: I consent to the SIP's request of my health information from other providers providing care to me, receipt of and release of my health information, whether written, verbal or electronic, for the uses described above as well as by the SIP's participation in any health information exchange described in the SIP's Notice of Privacy Practices (NPP). Please refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information. I understand and agree that Synapse Integrated Psychology can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of SIP's Notice of Privacy Practices which provides information on how the provider office may use or disclose protective health information (PHI) for purposes of treatment, payment, and/or health care operations, including consent for calls regarding payment/collections on any phone number provided. I understand that text and email communications are not encrypted and are not considered HIPAA- compliant forms of communicating health information. If I communicate with SIP or my provider using text or email, I waive the expectation of privacy of the information that is shared.

FINANCIAL RESPONSIBILITY

I have received a copy of SIP's financial agreement and consent to abide by its terms.

PERSONAL VALUABLES

I understand that the Synapse Integrated Psychology does not accept responsibility for any lost, stolen and/or damaged personal items while I am at the Synapse Integrated Psychology. I also agree to refrain from bringing any fire arms or weapons to SIP property.

ACCESS TO ONLINE COMMUNICATIONS (PATIENT PORTAL)

Online communications do not decrease or diminish any of the other ways in which you can communicate with your provider. It is an additional option and not a replacement. The Practice may stop providing online communications with you or change the services provided online at any time without prior notification to you.

I acknowledge that if I use the patient portal, I will review and consent to the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communications between me and my physician's office. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this Agreement. All of my questions have been answered and I understand and concur with the information.

DISCHARGE

I understand that any deposit or positive balance I have will be forfeit if I am discharged for the following reasons, or if I do not communicate with the clinic for more than 3 months. The following are reasons that I may be discharged from this practice. I understand that SIP will attempt to contact me to address these issues prior to discharge:

- Abusive or disrespectful language or behavior towards any staff person at Synapse Integrated Psychology.
- Intentionally mis-representing or with-holding important information about my condition, treatment, or illness.
- Repeated missed appointments including no-shows, late cancellations (less than 24 hours), or same-day rescheduling.
- Not putting the time or effort into treatment that is needed to make progress.
- Having an overdue or unpaid charge for more than 1 month, with no attempts to make arrangements or resolve my balance.

_____

Patient or Legal Representative Signature *Date of Signature* *Relationship of Legal Representative*

RELEASE OF INFORMATION

I give my permission for the office staff to leave a message on my voicemail regarding:

_____Appointment reminders _____Protected Health Information _____Requests for return phone call _____None

I give my permission for the office staff to text my cell regarding:

_____Appointment reminders _____ Protected Health Information _____Requests for return phone call _____None

I give my permission for the office staff to contact me at my place of employment if absolutely necessary: _____yes _____no