Holistic Touch Healthcare Services Intake Form

Date: Agency Use Only: Client#

CLIENT INFORMATION

First Name	Middle	Last
Address		
City	State	Zip
Cell Phone:	Alternative Phone:	County
Date of Birth	Sex	Social Security #
Race: African American ☐ White ☐ Hispanic ☐ Asian ☐ Other: _____		
Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐		
Referred By:		
Email Address:		

POA/GUARDIAN (if applicable)

First Name	Middle	Last
Address		
City	State	Zip
Cell Phone:	Alternative Phone:	County
Client's Relationship ☐ Parent ☐ Spouse ☐ Child ☐ Other		

EMERGENCY CONTACT

First Name	Middle	Last
Address		
City	State	Zip
Cell Phone:	Alternative Phone:	County
Client's Relationship ☐ Parent ☐ Spouse ☐ Child ☐ Other		

EMPLOYMENT

Are you Employed? ☐ Yes ☐ No	Company Name
	Address

ALLERGIES

Do you have any allergies? (Food, medication, other) ☐ Yes ☐ No	Allergies:

PRIMARY CARE PHYSICIAN

First Name	Last	Office Phone
Address		
City	State	Zip
Last Primary Care Visit:		

Pharmacy: _____

Pharmacy Phone Number:
_____

Name of Medication	Dosage	Prescribing Physician

_____ _____

Signature of Client or POA/Guardian (if applicable) **Date**

_____ _____

Signature of Holistic Touch Healthcare Clinical Staff **Date**

Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEATLH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices that are described in this Notice while it is in effect. This Notice takes effect ___/___/___, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCOLURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operation includes quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other

person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of you incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0 for each page. $20 per hour for staff time locate and copy you health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in

writing). Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Canitra White

Telephone: 800 3326647

Address: 311 West Saratoga Street, Baltimore MD, 21201_____

Benzodiazepine and Stimulant Agreement

Benzodiazepine, Stimulant and Hypnotic Agreement for

Holistic Touch Healthcare services

Patient's Name:

_____

My provider may agree to prescribe a benzodiazepine (like Klonopin, Xanax or Ativan), stimulants and hypnotics to control the symptoms of my psychiatric illness (or manage a side effect from a primary medication) and to help me function better in my life.

I understand the following about benzodiazepine medications:

- **If I use a Benzodiazepine daily, they will become less effective over time**
- **This is a TEMPORARY treatment**
- **I could suffer withdrawal symptoms if I stop a benzodiazepine suddenly**
- **Benzodiazepine withdrawal can be deadly in some cases**
- **There is a risk of addiction with benzodiazepine use**
- **Benzodiazepines have multiple long-term side effects, including memory disturbance and increased risk for Alzheimer's Disease**

These medications are often abused and are **extremely dangerous** when used improperly. For this reason, and others, I agree to the following rules regarding my use of medications:

- I will take medications at the dose prescribed by my provider
- I will take medications at the frequency prescribed by my provider
- I will not change how I take these medications without the prior approval of my provider
- I will not request early refills
- Lost or stolen medications will not be replaced; I am responsible for my medications
- I will arrange for refills at the prescribed interval only during clinical hours
- All prescriptions will be written, at maximum, on a 28-day schedule unless otherwise noted
- I will not request these types of medications from ANY other providers without the approval of my OTC approval
- I will keep my medication list updated and current with Holistic Touch healthcare LLC

- I will keep appointments with my psychiatric provider at Holistic Touch Healthcare LLC
- I will not receive any controlled substance prescriptions, if I am currently prescribed any other controlled substances.
- I will not receive controlled substances if I have a previous substance abuse history.
- I am required to actively participate in the treatment plan as described by my provider, this could include groups and/or one on one therapy
- I agree that I will not use illicit marijuana, alcohol or other illicit substances while taking this medication
- I agree that I may be subject to random urine drug screens and pill counts
- I understand that if my urine drug screen indicates that I am not taking these medications my provider will stop these medications
- I understand that if my pill count suggests that I am taking the medication differently than prescribed my provider will stop these medications
- I will not sell, trade or give my prescription medication to anyone. I will keep these medications away from children
- I understand that failure to comply with the above may cause my provider to STOP prescribing these medications
- I understand that if I do not show improvement in symptoms that my provider will stop prescribing these medication
- I understand that while being prescribed this medication, currently lab work and EKG may be requested
- I understand that my provider may stop these medications if I show significant side effects from these medications or demonstrate a problematic tolerance
- If my provider stops prescribing me benzodiazepines, they will stop them in the safest manner possible
- I agree that my dose might NOT be increased and could be tapered then discontinued

I have read this agreement and agree to all terms as outlined above.

Patient Signature: _____

Date and Time: _____

Provider's Name and Signature date and time

Dr. Gloria A. Ojo ————————————————-

Patient Consent for Treatment: Face-to-Face and Tele-health Services

By signing this form, I verify that I understand and voluntarily accept all terms, services, practices, and policies explained in **Holistic Touch Healthcare Services LLC** Patient Handbook and by my provider. I voluntarily consent to psychiatric and/or mental health services provided by **Holistic Touch Healthcare Services LLC** providers. I understand and accept the scope of services, session structure, cancellation and no-show policy, contact information, and the use of technologies to provide treatment. I also confirm that I understand and voluntarily agree to the following:

1. I understand the concepts and conditions of informed consents, privacy and confidentiality.
2. I understand that I can discuss these concepts and conditions and to ask for clarification of parts which I am concerned about or do not fully understand.
3. I understand that I will be informed of the goals, expectations, procedures, benefits, and possible risks involved in the evaluation and treatment/therapy.
4. When using telemedicine services, technical issues could affect a session if there is a poor connection or non-functioning equipment.
5. I understand that all communication will be private, legally privileged, and confidential unless otherwise specified by the specific laws presented below or unless I provide my written consent with a specified release of information.
6. I also understand that there are no guarantees of positive outcome for the treatment/therapy.
7. If I have health insurance, I understand that I am responsible for confirming coverage and network status before I receive treatment and that I am responsible for payment when services are not covered by my plan.
8. I understand that applicable payment is due at the time of service.
9. I understand that I may ask questions by secure message within the client portal anytime.
10. I understand that I am responsible for privacy related to the technologies that I use to connect with Kee Essentials services and that I must password-protect those technologies to increase the security of my information.
11. I understand that I may be immediately discharged if my behavior is a threat to my provider(s) or the property of **Holistic Touch Healthcare Services LLC.**
12. Upon such discharge, I understand that I will be given a list of alternate providers in my area from which I may choose a new provider for the continuation of my psychiatric care. I understand I am free to choose another provider that is not on the referral list and that I am responsible for making appointments immediately to prevent gaps in my care.
13. I understand that I may revoke consent and cancel treatment at will.

Patient Name (Last, First) _____DOB_____

Patient Signature to Signify Agreement with Terms----------

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully. 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

When it comes to your health information, you have certain rights.

This section explains your rights ad some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Ask us to connect your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- 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 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 of 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 act someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about you health information.
- We will make sure the person has this authority and can 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 our "Contact Us" website page www.Holistictouchhealthcare.com or via email at info@holistictouchhealthcare.com
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.
- 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.

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
- 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.

We typically use or share your health information to in the following ways:

- To treat you
- To share your information with other professionals who are also treating you
- Run our organization
- Improve your care and contact you when necessary
- Bill for your services
- Address workers' compensation, laws enforcement, and other government requests
- Help with public health, research, and safety issues such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
    - Comply with law
    - We can share health information with a coroner, medical examiner, or funeral director when an individual die

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
- 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.

Client Safety Contract

I, _____ (client), hereby contract with **Holistic Touch Healthcare Services LLC** /Mental Health Center Provider/Clinician), that I will take the following actions if I feel suicidal.

1. **I will NOT attempt suicide.**
2. I will phone _____ at _____.
3. If I do not **reach Dr. Gloria Ojo or my assigned provider** _____, I will phone any of the following services:

Name/Agency:	**Phone:**
http://www.aamentalhealth.org/pr_warmline.	**410-768-5522**
National Suicide Prevention Hotlines	**1-800-SUICIDE (784-2433) or 1-800-273-TALK (8255)**
Disaster Distress (Helpline Offers Immediate Crisis Counseling)	**1800-985-5990 or text "TalkWithUs" to 66746**
	1-800-985-5990 or test "Hablanos" to 66746 (Spanish)

4. I will further seek support from any of the following people:

Name:	**Phone:**
_____	_____
_____	_____

5. If none of these actions are helpful or not available, I will go to the ER at one of the following:

Hospital and Address:	**Phone:**
_____	_____
_____	_____

6. **If I am unable to get help or am unable to go to the hospital, I will call 911 and request help.**

Client's Signature: _____ Date: _____

Holistic Touch Healthcare Services LLC: Tele-Psychiatry

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a Tele-health consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a Tele-health consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the Tele-health consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH **BY DOXY.ME**

Tele-health by **Doxy.me t**he technology service we will use to conduct Tele-health videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Tele-health **by DOXY. ME** is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Tele-health Service, neither **Doxy.me** nor the Tele-health Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Tele-health by Doxy.me Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Tele-health by Doxy.me Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Tele-health Doxy.me Service.
5. To maintain confidentiality, I will not share my Tele-health appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING ON BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature_____

DATE_____

Informed Consent for Psychotropic Medications

By electronically signing this form, I verify that I voluntarily consent to receiving prescriptions from my provider for psychiatric medications as a part of my treatment with **Holistic Touch Healthcare Services LLC**

I also confirm that I understand and voluntarily agree to the following.

1. I am entitled to receiving information about the medications I am prescribed.
2. I understand that information about my medications will be provided in oral, and electronic form by my provider before any medication is prescribed.
3. I understand that my prescriber of record will also ask me to provide voluntary verbal consent for any new medications, medication changes, and/or the discontinuation of medications before they are ordered. Such verbal consent confirms that information about my medications was explained to my satisfaction and will be binding as noted in my health record.
4. I understand psychotropic medications may have risks that include side effects, age-related risks, rare and potentially life-threatening side effects, as well as fetal risk for pregnant women. If I am a woman and have a possibility of pregnancy, I understand that I must tell my provider immediately to assess the risks and benefits of taking my prescribed medications.
5. I acknowledge my right to refuse any medication dose or withdrawal my consent for medications at any time.
6. I understand that having psychotropic medications prescribed by a non-Holistic Touch Healthcare provider, except in a psychiatric urgency or emergency that warrants it, may result in immediate discharge and end my patient-provider relationships with Holistic Touch Healthcare Services. Upon such discharge, I understand that I will be given a list of alternate providers in my area from which I may choose for the continuation of my psychiatric care. I understand I am responsible for making those appointments immediately to prevent gaps in my care.
7. I understand that I can print this consent form at will.

Patient Name (Last, First)

_____

Patient Date of Birth (xx/xx/xxxx)

_____

Patient Signature to Signify Agreement with Terms

_____

Consent to Mental Health Services

Your signature on this form confirms your consent to mental health services to be rendered to you or a person for whom you are a legal representative or are a legal guardian *(Power of Attorney)*. The details of such mental health services have been explained to you as well as the risks and benefits of treatment, of alternative treatments, and of no treatment at all. You also understand there is NO GUARANTEE that any particular result will be achieved.

DO NOT SIGN THE FORM IF YOU HAVE ANY QUESTIONS THAT YOU THINK IMPORTANT TO YOUR DECISION AND CONSENT.

I understand and agree to mental health services that Holistic Touch Healthcare is qualified to provide within:

1. The scope of the provider's license, certification, and training; or
2. The scope of the license, certification, and training of those mental health providers directly supervising the services I receive.

{Holistic Touch Healthcare Services} Client Handbook Receipt

I, _____ *(Client name),* acknowledge that:

- I have had the Client's Rights and Grievance Procedure explained to me. A copy of these rights and procedures was given to me.
- I have been provided a copy of the Notice of Privacy Practices and have been notified of how my health information may be used and disclosed by Holistic Touch Healthcare and how I may access and control this information.

By signing below, I also consent to use and/or disclosure my health information to treat me and arrange for my mental health care, to seek and receive payment for services given me, and for the business operations of Holistic Touch Healthcare and its staff.

_____ _____

Signature of Client POA/Guardian (if applicable) **Date**

_____

Relationship to Client if POA

_____ _____

Signature of Holistic Touch Clinical Staff **Date**

For office use only: If the client does not sign this acknowledgment and consent form, record here the good faith efforts made to obtain this acknowledgment and consent or reason for lack of signature.

PRACTICE POLICIES

BILLING, FEES, APPOINTMENTS, NO-SHOWS, TARDINESS, CANCELLATIONS

(1) Please make every effort to cancel or reschedule 24 hours in advance if you need to. You will be responsible for the cancellation fee of **$75.00** for less than 24 hours cancelation or no call/ no show visits. You are responsible to set your appointment time reminders and confirm your appointment with us by sending email to us @ info@holistictouchhealthcare.com or calling the office @ 410 595 5029

(2) Practice consents, new patient intake questionnaires, and insurance name and identification/group numbers MUST BE completed at least 48 hours prior to your scheduled appointment.

(3) You have a 15-minute grace period prior to being considered a No-Show and/or late. Showing up for an appointment after the 15-minute grace period is considered late. You will be charged the entire visit fee.

(4) The standard meeting time for appointments are between 15-60 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the session needs to be discussed with the provider in order for time to be scheduled in advance.

(5) A $20.00 service charge will be charged for any attempted payments via credit card and payments returned for any reason by bank for special handling.

(6) Clients using credit card payments for cash pay visits will be charged an additional $5.00 transaction fee.

(7) Cancellations and re-scheduled appointments will be subject to a full charge by you to Holistic touch Healthcare services.

(8) If you are late for an appointment within your 15-minute grace period, you may lose some of that appointment time and extra time **WILL NOT be provided/given** to cover your scheduled visit. You will be charged the full visit costs.

(9) You are responsible to contact your insurance carrier to verify your tele-psychiatry (videoconference)/office visit eligibility benefits. If you have an appointment and seen during your scheduled appointment time, then realize your insurance is not valid, you will be charged the full cost of the visit to Holistic touch health care services. If you are in a different time zone, you are responsible to visit Holistic touch Healthcare on an Eastern Standard Time Zone. This is necessary because a time commitment is made to you and is held exclusively for you.

(10) All outstanding balances are expected to be paid in full at the time of your scheduled appointment.

(11) If you have deductibles to meet prior to your insurance paying visit costs. You are responsible for all visit charges.

(12) **Credit Card Authorization:** Upon receipt of entering my credit card information and my signature, I authorize Holistic Touch healthcare services LLC to bill all charges for which I am financially responsible, including no-show visits. I further understand that my credit card will be charged for any outstanding balance including a 1.5% interest late charge with no waiting period. Subsequently, I authorize {Holistic touch Healthcare LLC to bill my account **balance** to my credit card immediately, and thereafter in the event a balance exists. I understand that my credit card will not be charged if I choose to pay for treatment in person at the time of each appointment.

(13) I will notify Holistic Touch Healthcare immediately of any changes to my credit card. I acknowledge that I am fully responsible for all services received and any late fees accrued at Holistic Touch

(14) You are responsible for any unpaid balances.

DISABILITY, TRANSPORTATION, UTILITY COMPANY, etc. PAPERWORK

1. Paperwork completion for any kind and/or paperwork for community resources will cost $45 -100.00 per occurrence. Paperwork of any kind will not be completed prior to at least 6-9 months frequent and completed visits except you are able to prove your case is emergent and detrimental to your well-being. Full compliance with appointments is mandatory for paperwork completion. Letter request fee for work, school, etc. is $50-100.00 per request. Correspondence may take up 5-7 days to be completed.
2. Emotional service animal letters cost $35.00 per each occurrence and will be provided within 48hrs of your request.

WE DO NOT COMPLETE DISABILITY PAPERWORK, however, YOUR RECORDS and/or A DIAGNOSIS LETTER CAN BE PROVIDED. Please utilize your psychologist, therapist or counselor for the completion of disability paperwork.

ALL SCHEDULED VISITS

(1) If you sign a contract for concierge monthly visits and if your medications require you to return monthly for refills, you are expected to pay a $150.00 monthly concierge membership fee.

(2) You may be required to return at least bi-weekly for medication evaluations.

(3) Three no-shows can jeopardize your ability to continue receiving care from **Holistic Touch Healthcare Services LLC.**

(4) During your visit, a follow-up appointment will be given to you by your provider. Please note that You are fully and 100% responsible for selecting a method of appointment notification reminders on your own. We will make efforts to send electronic reminders and or call to ensure you can be reminded, cancel, or confirm your appointment with your provider. If you are unable to keep your appointment, please have the

courtesy to cancel your appointment before 24 hours in advance Unless you will be charged a minimum of $75 to maximum charge of $120.

For your first 2 missed appointments or cancelation/no shows, less than 24hrs of your scheduled appointment, you will be charged a total $75.00, your 3rd and up to 6th missed or more for less than 24 hours cancelation or no shows will result in you paying $120 before you can schedule to see your provider.

MEDICATION REFILLS

(1) A medication refill outside of appointment schedule requires a $35 fee.

(2) Schedule an appointment if you are having side effects with your medications. **Medications will NOT be adjusted or changed without a visit.**

TELEPHONE ACCESSIBILITY

(1) If a true emergency arises, please call 911 or any local emergency room.

(2) Telephone consultation calls are available. $125.00 /20 minutes increments ($375.00/hour) will be charged for non-members/non-clients outside of routine scheduled evaluation/medication management appointments.

SOCIAL MEDIA AND TELECOMMUNICATION Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, it may take more than 24hrs to respond. While I may try to return text messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of Ohio, Maryland, Arizona and Oregon. Under the Ohio, Maryland, Arizona and Oregon's Telemedicine Act, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your provider chose to use information technology for some or all of your treatment, you need to understand that: (1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would

otherwise be entitled. (2) All existing confidentiality protections are equally applicable. (3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee. (4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent. (5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to treatment, better continuity of care, and reduction of lost work time and travel costs.

Effective treatment is often facilitated when the therapist/provider gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Providers may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the provider's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the provider not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the provider.

TERMINATION Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment if I determine that the psychiatric treatment is not being effectively used, you need a higher level of care, for aggressive behavior or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons in-person or notifying you by certified mail and purpose of terminating. If you are non-compliant with mandatory treatment recommendation (labs, PCP visits, urine drug screens, follow-up visits, etc.) or if you need a higher level of care, you are subject to a termination. If treatment is terminated for any reason or you request another provider, I will provide you with a list of qualified mental health providers to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment every 90 days, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

X SIGNATURE _____

Date_____