CONSENT TO TREAT and STATEMENT OF CLIENT RIGHTS

I am voluntarily choosing to have psychological and/or: psychiatric treatment and hereby acknowledge that I am over eighteen (18) years of age, of sound mind and competent to consent to treatment, I hereby verify that I understand the services that the patient (who is myself or a child/individual for whom I have legal custody or guardianship) will receive at Independent Behavioral Health Group. The risks, benefits and alternatives to treatment have been explained to my satisfaction. I understand that the result of such treatment cannot be warranted or guaranteed, understand that I WILL be responsible for participating in the development of my own treatment plan.

I may terminate or request a change in the professional treating me at any time. understand that it is my right and responsibility to voice any concerns, objections or doubts I may have regarding the course of treatment to the professionals with whom I am in treatment or the director of the clinic.

Violation of federal law and regulation by a clinic is a crime, Suspected violations may' be reported to appropriate authorities in accordance with federal regulations, Federal law and regulation does not protect any information about a crime committed by a patient either at the clinic or against any person who-works for the clinic or about any threat to commit such crime. Federal law and regulation do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Understandings Regarding Termination from Treatment
I understand that I may be terminated from treatment non-voluntarily for the following reasons:
1. If I exhibit physical violence, verbal abuse, carry weapons, or engage in illegal acts at the clinic.
2. If I refuse to comply with stipulated program case protocol or refuse to comply with treatment recommendations.
3. If I am unable to schedule or attend appointments at assigned times.
4. If I am Judged to have symptoms that cannot be adequately treated with the resources available at Independent Behavioral Health Group.

I understand that I will be notified of non-voluntary discharge by my therapist, but that this is seen as a last resort when other, fee's drastic measures have proven ineffective. I may appeal this decision with the director of the clinic or request to re-apply for service later.

Other Understandings
*I understand that I may be contacted by telephone or mail for purposes of scheduling, billing, or other reasons. If there are any restrictions placed on contacting me or where bills may be sent, I will inform the office in writing.
*I understand that I may be contacted after completion of my treatment as a follow up to services provided.
*I understand that my medical record may be kept for several years and that in time it will be shredded or otherwise disposed of in such a manner that confidentiality will be maintained.

Medical Information Disclosure

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT you MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

HOW WE MAY use AND DISCLOSE YOUR PROTECTED MENTAL HEALTH INFORMATION

We use and disclose protected health information for a variety of reasons. Por most uses/disclosures, we must obtain your consent. However, the law provides that we are permitted to make some uses/disclosures without your consent. The following offers more description and examples of our potential uses/disclosures of your protected health information.
*__For treatment:__ We may disclose your protected health information to other mental health care practitioners within Independent Behavioral Health Group who are involved in providing your mental health care, However, a release of information is required to disclose your protected health information to mental health care practitioners outside of Independent Behavioral Health Group. For example, a referral to a mental health practitioner for assessment and/or long-term treatment would require a signed consent form from you for us to re/open and/or receive protected health information about you to appropriately coordinate your core.
__For mental health care operations:__ We may use/disclose your protected health information during operating our clinic. For example, we may use your protected health information in evaluating the quality of services provided creating reports that do not individually Identify you or disclose your protected health Information to our accountant or attorney for audit purposes. We may disclose your protected health information to designated scoff in the clinic where you are seen, and our administrative offices,
*__Exceptions:__ Although your consent is usually required for the use/disclosure of your protected health information, the law allows us to use/disclose your protected health information without your consent in certain situations. For example, we may disclose your protected health information if needed for emergency treatment if it is not reasonably possible to obtain your consent prior to the disclosure and we think that you would give consent If able.

__Uses and Disclosures Requiring Authorization:__ For uses and disclosures beyond treatment and operations purposes we are required to have your written authorization (signed permission), unless the use or disclosure falls within one of the exceptions described below. Like consents, authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already acted upon your authorization, uses and Disclosures Not Requiring Consent or Authorization: The law provides. that we may use/disclose your protected health information without consent or authorization in the following circumstances:

__When required by law:__ We may disclose protected health information when a law requires that we report Information about:
• Suspected abuse
• Neglect
• In response to a court order
• To Protective Services during an investigation

__Uses and Disclosure Requiring You to Have an Opportunity to Object:__ In the following situations, we may disclose your protected health information if we Inform you about the disclosure in advance and you do not object, However, if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.
• To families, friends or others involved in your care: We may share with these people information directly related to your family's, friend's or other person's involvement in your care. We may also share protected health information with these people to notify them about your location or general condition, for example, parents of a minor have certain rights to protected health information. Afro, we may have to locate family members to inform them of the location of a client who was hospitalized after being diagnosed as severely depressed.

INDIVIDUAL RIGHTS

Independent Behavioral Health Group provides quality services, it is our policy that each patient, defined as an Individual who receives services from Independent Behavioral Health Group and who meets admission criteria, be treated with dignity and respect regardless of race, color, national origin, religion, sex, ethnicity, age, disability, marital status, sexual preference or political beliefs.

In most cases you have the right to look at or get a copy of your health information, you also have the right to receive a list of instances Where we have disclosed health Information about you for reasons other than treatment, payment or related administrative purposes. If you believe information In your record is incorrect or that important information is missing, you have the right to request that we correct the existing information or add the missing information, You may request in writing that we not use or disclose your information for treatment, payment and administrative purpose except when specifically authorized by you, when required by law, or in emergency circumstances, We will consider your request but are not legally required to accept it. To make requests related to your health records or for more information about our privacy practices, you may contact the Department of Health and Human Services office of Recipient Rights.

1. All civil rights guaranteed by state and federal law.
2. The right to reasonable access to treatment care and services.
3. The right to be treated with personal dignity.
4. The right to treatment, care and services that are considerate and respectful of individual personal values and beliefs.
5. The right to refuse treatment or services, should you (or your legally responsible party) refuse services, we may seek appropriate alternatives, such as orders of involuntary treatment, Should you consent to treatment but refuse specific services that are recommended for you, we may terminate the relationship with you upon reasonable notice and make a referral to another provider.
6. Freedom from abuse and neglect.
7. The right not to be fingerprinted, photographed, audiotaped, videotaped, or viewed through a one-way glass unless the patient or patient's legal representative agree in writing,
8. The right to treatment in a place that is clean and safe.
9. The right to informed participation in decisions regarding treatment, care, and services. This right is applied to children as appropriate to their age, maturity and clinical condition, and the right of the family of individuals to participate in such planning. Independent Behavioral Health Group expects that children 10 years or older will participate in the treatment planning process,
10. The right to individualized treatment, care and services, including a) adequate and human services regardless of the source of financial support; b) provision of services within the least restrictive environment possible; c) an individualized treatment plan, d) periodic review of the treatment plan and e) an adequate number of competent, qualified, and experienced staff to supervise and carry out the treatment plan.
11. The right of the individual served and their family to be informed of their rights in a language that they understand.
12. Each patient has the right to request a second opinion, a consult (at his or her expense), or to request an in-house review of the treatment plan. Such a request should be made to the Director.
13. SUBSTANCE ABUSE PATIENTS may present grievances or suggested changes in program policies and to the program staff, to governmental officials, or to another person within or outside the program in accordance with the promulgated administrative rules of the Office of Substance Abuse Service. In this process, Independent Behavioral Health Group will not, in any way, inhibit the recipient, upon admission, each substance abuse patient is provided with a brochure summarizing recipient rights specific to substance abuse patients entitled, "Know Your Rights," For additional information. Patients may contact the Department of Health and Human Services office of Recipient Rights.

Consent for Teletherapy

Teletherapy is the delivery of psychotherapeutic services using interactive audio and visual electronic systems and/or by the electronic transmission of information where the provider and the patient are not in the same physical location.

The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

Potential benefits

* A computer and a webcam can provide live video conferencing using software that can be free to patients.

* Teletherapy provides convenience and increased accessibility to mental health care for patients who are unable to be treated face to face due to various reasons such as living in remote locations, temporary circumstances such as being away at college, an extended stay away from home, or having a physical limitation preventing travel to our office.

Potential Risks

As with any mental health procedure, there may be potential risks associated with the use of teletherapy. These risks include, but may not be limited to:

* Information transmitted electronically may not be sufficient (e.g., poor resolution of video) to allow for appropriate decision making by the psychiatrist or the therapist.

* The provider is not able to provide every type of mental health treatment using interactive electronic equipment.

* The provider may not be able to provide for or arrange for emergency care that I may require, in cases of connection failure.

* Delays in mental health evaluation and treatment may occur due to deficiencies or failures of the equipment.

* Although unlikely, security protocols can fail, causing a breach of privacy of my confidential medical information.

* A lack of access to all the information that might be available in a face-to-face visit but not in a teletherapy session may result in errors in clinical judgment.

My Rights

* I understand that the laws that protect the privacy and confidentiality of medical information also apply to teletherapy.

* I understand that the videoconferencing technology used by the provider is encrypted to prevent unauthorized access to my private medical information.

* I have the right to withhold or withdraw my consent to the use of teletherapy during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.

* I understand that the provider has the right to withhold or withdraw his or her consent for the use of teletherapy during the course of my care at any time.

* I understand that the all rules and regulations that apply to the provider's practice in my state, also apply to teletherapy.

* I understand that the provider will not record any of our teletherapy sessions without my written consent.

* I understand that the provider will not allow any other individual to listen to, view or record my teletherapy session without my written permission.

My Responsibilities

* I will not record any teletherapy sessions without written consent from the provider. I will inform the provider if any other person can hear or see any part of our session before the session begins. The provider will not allow any other person to hear or see any part of our session.

* I understand that I, not the provider, am responsible for providing and configuring any electronic equipment used on my computer that is used for teletherapy. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.

OUR LEGAL DUTIES

We are required by law to protect the privacy of your Information, provide this notice about our information practices and follow the information practices that are described in this notice. We may change our policies at any time. Before we make a significant change in our policies, we will change this notice and post the new notice in public areas of the agency. You can also request a copy of our notice any time.

COMPLAINTS

If you are concerned that we have violated any of your rights, you may contact the Department of Health and Human Services Recipient Rights office, you may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

CONTACT INFORMATION

Call the MDI-IHS-ORR Hotline: 1-800-854-9090
Genesee County CMH Services: Recipient Rights Director, 420 W. Fifth Ave, Flint, MI 48503-2494
Office No. 810-257-3710 Fax No. 810-257-3790
Department of Health and Human Services: Office of the Secretary, 200 Independence Avenue, SW, Washington, DC 20201

OFFICE EXPECTATIONS

IMPORTANT INFORMATION FOR PATIENTS RECEIVING PSYCHIATRIC SERVICES

Independent Behavioral Health Group, makes every effort to assure that you are informed regarding the services you receive. Please read this document carefully because it provides important information that you need to know regarding the services you receive from our psychiatrists.

1. It is important that you keep all of your appointments with the psychiatrist as scheduled.

2. Twenty-four (24) hour notice is expected when you cancel an appointment with the psychiatrist. If you fail to give the clinic 24-hour notice, you may be charged a cancellation fee up to the full clinic fee. No show charges are not covered by your insurance.

3. It is essential that you take any prescribed medications as directed by the psychiatrist.

4. Women of childbearing age should avoid pregnancy while taking psychotropic medications. Women of childbearing age should notify the psychiatrist immediately if they intend to become pregnant or if there is a possibility they may be pregnant, i.e., they have experienced a missed period.

5. It is important that you assist your psychiatrist and other prescribers of medication in managing information about your medications so that your doctor can help make sure that the medicines you take can be safely used together. You should inform your personal physicians about any medications that are prescribed by your psychiatrist. You should also update your "Patient Medication List" whenever a personal physician prescribes a new medication for you. If you sign a Release of Information allowing us to communicate with your personal physicians, we will communicate with them to promote your well-being.

6. It is expected that you will obtain any laboratory tests as requested by your psychiatrist. Results of your laboratory investigations are available to you upon request.

7. It is expected that you will continue to see your therapist as well as your psychiatrist. While you may experience a reduction in symptoms after you begin taking your medication; you and your therapist need to work together to address underlying factors causing your symptoms.

8. If you fail to keep your appointments with either your psychiatrist or your therapist and you are receiving medications, a 30-day supply will be prescribed. After that time, you are expected to contact your family physician for continuation of your medication. After 30 days, our psychiatrists will no longer be responsible for your medications.

9. Patients who are seeing the psychiatrist because of disability are expected to bring disability forms to their appointments. In order to have your disability forms completed you must keep all appointments.

10. Independent Behavioral Health Group does not renew medications via telephone. All prescription renewals need to be obtained during an appointment with your psychiatrist. To avoid

running out of medications, you are expected to schedule and keep an appointment with the psychiatrist before your medication prescription expires.

If you have any questions about the services you are receiving, please feel free to bring your concerns to the Office Manager.

Payment Understandings

I understand that my insurance company, third party payer, or managed care representative may request such information or records as is necessary to process and verify billing claims or authorize treatment. From time to time, governmental agencies and accrediting bodies may survey the clinic and request information regarding patients' treatment to verify the clinic's adherence to standards. I give permission for the release of such information and records to my insurance company, governmental agencies, collection agencies, accrediting agencies or courts, for the purpose of billing and/or receiving payment for services or accreditation purposes. In some instances, the payer of services may require copies of progress notes from the medical record before making payment, A signed Authorization of Release of Confidential Information signed by me will not be necessary for Independent Behavioral Health Group to provide information to such other party necessary for billing and payment purposes.

If I have insurance coverage for treatment, Independent Behavioral Health Group may accept payment from the Insurance company, but independent Behavioral Health Group does not guarantee coverage or benefit amount5 and holds me ultimately responsible for payment. If Independent Behavioral Health Group bills a third party, i.e., a divorced spouse or other third person at my request and
that third party fails to make timely payment, I understand that I am ultimately responsible for payment. I understand that failure to provide required documents, such as an insurance card, will result in my being charged'.

I am aware of the charges for treatment services and understand that I am the financially responsible party for payment of services rendered as well as any late fees or costs arising from any court action should my account become delinquent. I understand that if my account becomes delinquent, Independent Behavioral Health Group may report the status of my account to a credit-reporting agency or agencies. I cannot assign my financial responsibility to any other individual unless an Independent Behavioral Health Group is provided with written consent by such other party, A form entitled "Acknowledgment of Financial Responsibility" provided by the clinic or other form providing the same information may be used for this purpose.

I understand that it is my responsibility to keep arranged appointment times or to notify of a need to cancel 24 hours in advance to avoid a missed appointment/late cancellation fee. This fee is due at the time of the next service.

Independent Behavioral Health Group
Medical Record Release
Phone: 810-733-5735 Fax: 810-733-5733
4413 Corunna Road Flint MI 48532

Patient's Name: Date of Birth:

I request and authorize:

Independent Behavioral Health Group
To release and request healthcare information of the patient named above with/from these persons and institutions :(please list an emergency contact)

1. Name:_____ Phone:_____ City: _____ Relation:_____
2. Name:_____ Phone:_____ City: _____ Relation:_____
3. Name:_____ Phone:_____ City: _____ Relation:_____
4. Name:_____ Phone:_____ City: _____ Relation:_____
5. Name:_____ Phone:_____ City: _____ Relation:_____
6. Name:_____ Phone:_____ City: _____ Relation:_____

This request and authorizations applies to the following information :

Our office coordinates with Primary Care Physicians:
I authorise the release and request healthcare information of the patient named above to my doctor.

Name: _____ Phone:_____

***Upon signing this packet I acknowledge and understand that I am consenting to treatment at Independent behavioral Health Group. I agree and understand the office expectations, individual rights, medical disclosure policies, consent to teletherapy, and agree to the financial agreement as well as the medical release authorization.**

***By inputting my electronic signature I acknowledge and understand that I have read of the policies aforementioned. I acknowledge that I am the person/ or the parent or guardian of the individual receiving services.**

If you are the parent or guardian of the patient please indicate the type of custody you have of the client. Parent/guardian of patients must provide any court ordered documentation with any continuation of therapy if applicable.

_____