New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

A. I _____, understand that Metamorphosis Psyche originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plans for future care or treatment. I further understand that it may become necessary to disclose my protected health information to another entity for treatment or payment purposes, and I consent to such disclosure for these permitted uses. I understand that Metamorphosis Psyche may either mail, email, or fax my medical records to the party requesting them. I agree with such modes of transmission.

B. I understand that the health information Metamorphosis Psyche gathers about me:

- Is necessary for planning my care and treatment;
- Will be shared among the many health professionals who contribute to my care; ● Will be shared with my health insurance company for billing purposes; and ● Will be used internally by Metamorphosis Psyche to measure patients' quality of care.

C. I further understand that:

- I have the right to object to the use of my health information being used for purposes not related to my care and treatment, or not related to billing my insurance company for the services I received.
- I have the right to restrict how my health information may be used or disclosed.
- I have the right to revoke my consent, in writing, at any time. I understand that if I later revoke my consent, the revocation doesn't apply to disclosures that Metamorphosis Psyche made prior to me revoking this consent, and Metamorphosis Psyche is not liable for any disclosures made in reliance to the signed (but not revoked) consent.
- I have the right to refuse to sign this consent. I understand that if I refuse to sign this consent, Metamorphosis Psyche may refuse to treat me as permitted by law.
- Lastly, I further understand that Metamorphosis Psyche reserves the right to change this notice without my approval. Should Metamorphosis Psyche change this notice, it will send a copy of any revised notice to the email address I have provided and/or to the mailing address I have provided (via U.S. Mail).

D. I wish to place the following restrictions on the use or disclosure of my health information:

_____

_____

_____

_____

Patient's Signature or Authorized Representative

_____

Today's Date

Office Policies & Procedures Agreement for Mental Health Services

This document provides you, the client, with information that is additional to the Consent to the Use and Disclosure Health Information and it is subject to the Health Insurance Portability and Accountability Act (HIPAA) preemptive analysis.

A. CONFIDENTIALITY: All information disclosed during the sessions with your psychiatric provider or mental health clinician (herein called provider) and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

B. WHEN DISCLOSURE IS REQUIRED, OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required or may be required by law are: (a) where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; (b) where a client presents a danger to self, to others, to property, or is gravely disabled; or (c) when a client's family members communicate to his/her provider that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental health status at issue in a litigation initiated by you (the patient/client), the defendant may have the right to obtain the psychiatric records.

In couple and family mental health services/counseling/therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Your provider will use his/her clinical judgment when revealing such information. Your provider will not release records to any outside party unless she is authorized to do so by all adult parties who were part of the family session/therapy/counseling, couple therapy/counseling or other treatment that involved more than one adult client.

C. EMERGENCY: If there is an emergency situation, or in the future after termination, where your provider becomes concerned: (a) about your personal safety; (b) the possibility of you injuring someone else, or (c) about you receiving proper psychiatric care, she/he will do whatever she/he can, within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the

proper medical care. For this purpose, she/he may also contact the emergency person whose name you have provided on the intake form.

D. HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance company to process Metamorphosis Psyche's claims for payment. If you instruct your provider, only the minimum necessary information will be communicated to the health insurance company. Your provider has no control over, or knowledge of, what insurance companies do with the information she submits or who has access to this information. You must be aware that submitting an invoice for payment or reimbursement for mental health services provided to you carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into the health insurance companies' electronic system and is likely to be reported to the National Medical Data Bank. Accessibility to health insurance companies' electronic systems or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to hacking and unauthorized access. There have been instances where medical data has been legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position.

E. LITIGATION LIMITATION: Due to the nature of the psychiatric therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on any of Metamorphosis Psyche's provider(s) to testify in court or at any other legal proceeding, nor will a disclosure of the psychiatric records be requested unless mandated by a judge.

F. CONSULTATION: Your provider at Metamorphosis Psyche consults regularly with other professionals regarding her/his clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

G. E-MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is very important to be aware that computers and email communication can be relatively easily accessed by unauthorized people and

hence can compromise the privacy and confidentiality of such communication. Faxes can easily be sent erroneously to the wrong address. Emails are particularly vulnerable to unauthorized access since internet servers have unlimited and direct access to all emails that go through them. It is important that you be aware that emails, faxes, and important texts are part of the medical records. Metamorphosis Psyche has taken all necessary steps to protect your health information by using encrypted emails, installing anti-virus protection software on all its computers, and using passwords on all computers. If you elect to receive communications from Metamorphosis Psyche electronically, please make sure that no one other than yourself has access to your email address, facsimile or cellphone. If you chose to send an email to Metamorphosis Psyche, please make sure that the email is encrypted to limit instances of disclosure to a non-authorized party.

H. RECORDS AND YOUR RIGHT TO REVIEW THEM: Metamorphosis Psyche will retain your health records for at least seven (7) years as required by both Federal and Florida laws. If you have concerns regarding the storage of your medical records, please discuss them with the owner of Metamorphosis Psyche. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when your provider assesses that releasing such information might be harmful to you in any way. In such an event, your provider will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, Metamorphosis Psyche will release information to any agency/person you specify unless your provider determines that releasing such information might be harmful to you. When more than one client is involved in treatment, such as in cases of couples and family mental health services, your provider will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment**. Please note that Metamorphosis Psyche charges a cost of $1.00 per page for the first 25 pages, and 25 cents per page for each additional page thereafter for either emailing, faxing or photocopying medical records requested by its patients/clients. There is an additional charge of $10 for mailing any medical records. There is a 6-8 week process time for medical records requests.**

I. TELEPHONE & EMERGENCY PROCEDURES: If you need to contact the provider between sessions, please contact the office and leave a message at (954) 906-4106 and your call will be returned as

soon as possible. You may also email the office at cbadmin@metamorphosispsyche.com and your email will be returned as soon as possible. Metamorphosis Psyche staff checks voice messages and emails several times during normal business hours. Please note that the staff does not check messages or emails when the office is closed or during holidays. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away then call the 24-hour crisis line by dialing 2-1-1, or contact the Police by dialing 9-1-1. You may also go to your local emergency room for all psychiatric or medical emergencies. Please do not use text messages or faxes to notify providers of emergency situations.

J. PAYMENTS & INSURANCE REIMBURSEMENT: Clients/patients are expected to pay the standard copay fee per their In-Network & Out of Network healthcare insurance plans; this is based on clients' insurance plan coverage. After payment by her/his health insurance company, a client may have a patient responsibility owed to Metamorphosis Psyche. Clients are expected to pay the amount owed to Metamorphosis Psyche immediately upon receipt of the billing statement/invoice. There is a standard office fee of $25.00 for all clients who are seen in the office and it must be paid along with copay amount if applicable.

Self-pay clients office fee is included in their rates. Self-pay clients are expected to pay $350 for the initial evaluation (IPE) per 45-60 minutes and for follow-up evaluations $200 (FUE) per 20-30 minutes. Sliding scales are available for Medicare & Medicaid clients. **Income-based sliding scales** are available for clients who qualify. He/she will need to provide proof of income for verification (i.e., current tax return). **The requirement for proof of income [tax return] verification is on a yearly basis prior to the first scheduled appointment for the calendar year.** Otherwise, you will be subject to the highest self-pay rate. Sliding scale rates vary between $250 and $175.00 for IPE per 45-60 minutes, and $150.00 - $100.00 for follow-up evaluations (FUE) per 20-30 minutes session. These rates are subject to change at any given time in the future.

Payments are due before each psychiatric evaluation unless other arrangements have been made and agreed upon by Metamorphosis Psyche. Receipts of payment are given the day of psychiatric evaluation. Telephone consultations, telehealth/telemedicine, site visits, writing and reading of reports, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify the provider or his/her administrative staff if any problems arise during the course of your mental health/psychiatric services regarding your ability to make payments. For clients with no mental health insurance coverage,

the provider will provide you with a copy of your receipt per consultation, which you can then submit to your insurance company for reimbursement if you so choose. As was indicated in the section, Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in psychiatry, are reimbursed by insurance companies. It is your responsibility to verify the specifications of your coverage. If your account is overdue (unpaid) and there is no written agreement of a payment plan, the provider can use legal or other means (courts, collection agencies, etc.) to obtain payment.

K. MEDIATION & ARBITRATION: All disputes arising out of, or in relation to, this agreement to provide mental health services shall first be referred to mediation, before, and as a precondition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of the provider and the patient/client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in (Broward County, Florida) in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, if your account is overdue (unpaid) and there is no agreement on a payment plan, your provider can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

L. THE PROCESS OF PSYCHIATRIC EVALUATION AND SCOPE OF PRACTICE: Participation in mental health services can result in several benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek psychiatric care. Working toward these benefits, however, requires effort on your part. Psychiatric care requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. The provider will ask for your feedback and views on your mental health progress, other aspects of the mental health services you received, and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you

experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. The provider may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed.

Attempting to resolve issues that brought you to seek mental health services in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychiatric care may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychiatric care will yield positive or intended results. During the course of the mental health services, the provider is likely to draw on various psychological approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive behavioral, motivational, coaching, mindfulness, integrative, person-centered, cultural sensitive, spiritual, or psycho-educational. The provider does not provide neither custody evaluation recommendation nor legal advice, as these activities do not fall within her/his scope of practice.

M. TREATMENT PLANS: Within a reasonable period of time after the initiation of treatment, your provider will discuss with you her/his working understanding of the problem, diagnosis (es), treatment plan, therapeutic objectives, and her/his view of the possible outcomes of treatment. If you have any unanswered questions about the course of your mental health services, provider's expertise in employing them, or about your treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatment options for your condition and their risks and benefits.

N. TERMINATION: As set forth above, after the first couple of consultations, the provider will assess if he/she can be of any benefit to you. The provider does not accept clients who, in her/his opinion, she/he cannot help. In such a case, she/he may give you several referrals whom you can contact. If at any point during your mental health services, the provider assesses that she/he is not effective in helping you reach your mental health or therapeutic goals or that you are non-compliant, she/he is obligated to discuss it with you and, if appropriate, terminate treatment services. In such a case, she/he

may give you several referrals that may be of help to you. Providers are not obligated to give referrals for terminated cases. If you request it and authorize it in writing, the provider (if willing) may talk to the psychiatrist or psychotherapist of your choice in order to help with the transition. The patient/client may, at any time, may consult with another psychiatrist or therapist for another professional's opinion. You have the right to terminate mental health services at any time.

O. DUAL RELATIONSHIPS: Despite a popular perception, not all dual or multiple relationships are unethical or avoidable. Psychiatric care never involves sexual or any other dual relationship that impairs the provider's objectivity, clinical judgment or can be exploitative in nature. The provider will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. It is important to realize that in some communities, particularly small towns, military bases, university campuses, etc., multiple relationships are either unavoidable or expected. Your provider will never acknowledge working with anyone without his or her written permission. Clients have chosen the provider as their mental health psychiatric provider because they knew her/him before they entered mental health services with her/him, and/or are personally aware of her/his professional work and achievements. Nevertheless, the provider will discuss with you the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know which ahead of time. It is your responsibility to advise the provider if the dual or multiple relationship becomes uncomfortable for you in any way. The provider will always listen carefully and respond to your feedback and will discontinue the dual relationship if she/he finds it interfering with the effectiveness of psychiatric care or your welfare and, of course, you can do the same at any time.

P. SOCIAL NETWORKING AND INTERNET SEARCHES: At times, a provider may conduct a web search on his/her clients before the beginning or during mental health services. If you have concerns or questions regarding this practice, please discuss them with the provider. Providers do not accept friend requests from current or former clients on their personal social networking sites, such as Facebook. The provider recognizes that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, the provider requests that clients not communicate with her/him via any interactive or social networking sites.

Q. CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 business hours (1 business day) notice is required for rescheduling or canceling an appointment. Unless we reach a different agreement, a cancellation fee will be charged for sessions missed without such notification. **[Refer to page 12 of this policy for further information regarding cancellation, rescheduling, and no-show fees].**

R. DISABILITY OR FMLA: The provider must develop a rapport and professional provider client relationship with the client for at least one year before completing Disability or FMLA documentation for mental health conditions/disorders. Clients have to follow up for all consecutive scheduled psychiatric evaluations over the course of a minimum of one year of mental health services. The provider will not falsify any documentation about mental health disorders or mental health capacity for Disability or FMLA approval.

Note.: The cost to complete Disability or FMLA documentation is currently $50.00 and subject to change.

S. EMOTIONAL SUPPORT ANIMALS: In order to receive a valid emotional support letter, there has to be significant mental health distress that requires the use of an animal for love and companionship. The provider must develop a rapport and professional provider-client relationship for at least one year before such a letter will be given to the client. It will be written at the sole discretion of the provider.

Note: The cost to complete documentation for emotional support animals is currently $50.00 and subject to change.

I have read the above Office Policies and Procedures Agreement for Mental Health Services and Informed Consent for Mental Health Services carefully (a total of 14 pages). By signing below, I understand them and agree to comply with them:

Parent/Guardian Name (print) _____

Parent/Guardian Signature _____

Date _____

Client's Name (print) _____

Signature _____

Date _____

Psychiatric Provider Name (print) _____

Signature _____

Date _____

Revised: 08/2023

Cancellation and No-Show Policy

I.) Cancellation of an Appointment: Please be courteous and notify Metamorphosis Psyche, at least 24 business hours in advance, if you are unable to attend an appointment. If it is necessary to cancel your scheduled appointment, we require that you call or email 24 business hours in advance. If you call for a refill of your medications after you have canceled your follow-up appointment, this request may be denied until you have seen the doctor.

Follow-up appointments: For insured clients, the $50 nonrefundable fee must be paid prior to rescheduling an appointment. For self-pay clients, the nonrefundable fee will equal the cost of that day's evaluation and it must be paid prior to rescheduling an appointment.

Initial evaluations: If you are scheduled for an initial evaluation and do not show or cancel the appointment without 48 business hours' notification (2 business days), there will be a nonrefundable fee assessed in the amount of $100 for insured clients. For self-pay clients, the nonrefundable fee will equal the cost of that day's evaluation. Please note that these fees are nonrefundable and must be paid prior to rescheduling any appointments.

II.) How to Cancel Your Appointment : To cancel an appointment, please call (954)-906-4106 or feel free to email us at cbadmin@metamorphosispsyche.com. If you do not reach a member of the office administrative staff, you may leave a detailed message on the voicemail system.

III.) No-Show Policy : A "No Show" is someone who misses an appointment without canceling it at least 24 business hours prior to the scheduled appointment. For example: if your appointment is at 3:00 p.m. on Tuesday, you need to call or email us before 3:00 p.m. on Monday. "No-show" appointments inconvenience those individuals who need to come in to see a therapist/psychiatrist. Failure to attend a scheduled session without following the cancelation guidelines as indicated above or if you are 10 minutes late for the scheduled appointment will be recorded in your chart as a "No Show" and result in a nonrefundable fee as stated above.

I acknowledge and agree to pay the cancellation fee in full for any missed appointments and that these fees are non-refundable.

Patient's Name (Printed): _____

Patient/Parent's Signature: _____

Patient's Date of Birth: ___/___/_____ **Today's Date:** _____/____/_____

Misuse/Abuse of Drugs
PATIENT'S CONSENT TO RANDOM TESTING

This misuse/abuse of drugs testing consent agreement is made between the patient listed below and Metamorphosis Psyche. The patient agrees to be randomly tested for drugs when the doctor suspects that the patient may be misusing or abusing drugs, and if the patient is taking a controlled substance. The patient understands that she/he is responsible for the cost of the drug test which is $50.00.

PATIENT ACKNOWLEDGEMENT

This policy and authorization has been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy at any time, I can discuss my questions with my therapist

Patient's Name (Printed): _____

Patient's Date of Birth: _____/_____/_____

Patient/Guardian's Signature: _____

Today's Date: ____/____/_____

THIS PAGE IS FOR OFFICE USE ONLY:

[ ] Consent received by _____on_____.
[ ] Consent refused by patient on_____
[ ] Consent added to the patients' medical records on _____.

TREATMENT PLAN CONSENT FORM: Disclosure of Protected Health Information Log

Date & Time	Name of Requestor (Include Business Information)	Reason for Request	Information Requested* (BE SPECIFIC)	Known?	Approved By Doctor (If Applicable)
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	

Metamorphosis Psyche, LLC
6101 West Atlantic Blvd., Suite 202, Margate, FL 33063
Tel: (954) 906-4106 / Fax: (954) 906-4029