Comfort Minds & Above Behavioral Health
9500 Ray White Rd Ste 200
Fort Worth, Texas, US - 76244

Informed Consent for Treatment, HIPPA, Financial and CC Policy, Photo Release - ALL PATIENTS

Patient Full Name: *

Date of Birth: *

Address

Phone Number *

Email Address

Treatment Authorization

Provider Name: Shuntak Jerideau, PMHNP-BC

I authorize medical and health care treatment of myself or my minor child by Shuntak Jerideau PMHNP-BC.
I understand that as patient, I will receive care that will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided on day of service and over the course of several weeks, months, years for chronic conditions. Your questions, concerns and possible or potential side effects of natural, conventional and alternative treatments will be discussed and disclosed to you. Everyone is different and responds differently to treatments therefore not all reactions are documented and can be predicted. It is your responsibility to keep us informed of any medication or physical changes and diagnosis, so we can coordinate it with your care and prevent any interactions with your treatment plan.

PATIENT SIGNATURE *

Date *

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS NOT A RELEASE OF YOUR MEDICAL INFORMATION

This Notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. “PHI” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a

home agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission. HealthcareOperations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI in the following situations w without your authorizations.These situations include: Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates.Required uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500. Other Permitted and Required Uses and Disclosures will be made only with your consent. Authorization or Opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.Your Rights: You have the right to inspect and copy your PHI, under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request; even if you have agreed to accept this notice alternatively i.e. electronically. You may have the right to have your physician amend your PHI, if we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we've made, if any of your PHI we reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (817)745-4632.

Signature below is acknowledgement that I have received this notice of privacy practices.

PATIENT INITIALS *

Appointment Cancellation Policy

We understand that everyone has unplanned events that demand immediate attention and do require cancellation of appointments. However, please understand that your booked time is set aside especially for you. We schedule a up to an 1 hour for first appointment and 30 to 60 minutes for follow ups. When you cancel, that is time that another patient could have been booked and helped.If you must cancel with less than 24 hours notice, you will be charged $50.00 for your missed appointment.

PATIENT INITIALS *

Credit Card Authorization and On File Agreement

I authorize, Comfort Minds & Above, LLC to charge my credit/debit card for appointments, sessions, cancellation fees, and/or other incurred fees related to services provided by Comfort Minds & Above, LLC. I understand it is my responsibility to keep an updated copy of my credit/debit card information on file. If my credit/debit card is declined for any reason, I am responsible for immediate payment of the full balance by cash or check.

Name as it appears on card *

Type of Card * ☐ Visa ☐ Mastercard ☐ Amex ☐ Discover

Card Number *

Expiration Date *

CCV Code: (3 numbers on the back of the card) *

Billing Address *

Billing Zipcode *

I understand that there is a 24 hour cancellation notice policy and I will be charged for any missed appointments. I also agree by entering my name below I acknowledge I have electronically signed and agree to the terms of this form.

PATIENT INITIALS *

Financial Policy

The purpose of this policy is to assist you in maintaining a balance between the clinic (for services rendered) and your best interest. Comfort Minds & Above, LLC feels by maintaining an equitable balance, both communication and healing are furthered.

I hereby agree to any of the following:

If I choose private pay, I will pay for all services as they are rendered. Comfort Minds & Above, LLC prefers cash, however as a convenience, we will also accept credit cards.

If I choose PPO/Insurance/Group health, I acknowledge that I am responsible for reviewing and understanding my insurance benefits before time of service.

As a courtesy to you, we will gladly submit your medical bills to your insurance company; however, ultimately, you will be responsible directly to Comfort Minds & Above, LLC for full payment of your account if your insurance company fails to make a payment to us.

I understand that I am responsible for whatever co-payment, deductible, and non-covered services that my plan has set forth at the time the services are rendered.

I understand it is my responsibility to keep my medical record up to date with current address and insurance information so that billing can be done in a timely manner. Some insurance companies require claims be submitted within 7 days and if new insurance coverage is not provided prior to services, it will not be possible for us to bill or collect from your insurance carrier.

Checks returned by your bank will be subject to a $40 service fee.

There will be a $50.00 charge for all missed scheduled appointments that have not been cancelled with a 24 hour notice.

By signing below, I certify that I understand and agree to the financial policy presented to me by Comfort Minds & Above, LLC.

PATIENT INITIALS *

Photo and Video Release Consent

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes: ● Conference presentations ● Testimonials ● Video for marketing ● Educational presentations or courses ● Informational presentations ● On-line educational courses ● Educational Videos

By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting. I will be consulted about the use of the photographs or video recording for any purpose other than those listed above. There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed. This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only. By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

PATIENT INITIALS *

If this release is obtained from a presenter under the age of 19, then the signature of that presenter's parent or legal guardian is also required.

LEGAL GUARDIAN/PARENT SIGNATURE

By signing this form, I acknowledge that I have completely read this document in its entirety and understand the above disclaimers and agree to be bound thereby.

PATIENT SIGNATURE *

Date Signed *