ALEVEA MENTAL HEALTH

Save this file to your PC and digitally sign the areas listed below. If you cannot digitally sign, you can simply type your full name in the Sign areas. Upload the file in the New Patient Forms section, or fax to 602-419-3101, or email to info@aleveamentalhealth.com

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended psychiatric evaluation, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, evaluations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or physician assistant, nurse practitioner, or clinical nurse and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, evaluations, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

SIGN HERE

Signature of Patient or Personal Representative _____ Date: _____

Printed Name of Patient or Personal Representative _____ Relationship to Patient _____

Printed Name of Witness _____ Employee Job Title _____

Signature of Witness _____ Date _____

ALEVEA
MENTAL HEALTH

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	☐ YES	☐ NO
May we leave a voicemail on your at home phone or on your cell phone?	☐ YES	☐ NO
May we discuss your medical condition with any member of your family?	☐ YES	☐ NO

If YES, please name the members allowed:

_____

This consent was signed by: _____
(Please Print Name)

Signature: _____ SIGN HERE Date: _____

Witness: _____ Date: _____

ALEVEA
MENTAL HEALTH

NO-SHOW POLICY

Quality Care for our patients is a top priority. In order to provide the highest quality care in a timely manner, we have established a No-Show Policy. This policy enables us to better utilize available appointments to meet your healthcare needs, many times within the same day.

Please take a few minutes to review the policy and sign at the bottom of the form. If you have any questions please let us know.

DEFINITION OF A NO-SHOW POLICY

ALEVEA Mental Health defines a "No-Show" appointment as any appointment in which a patient does not show for an appointment, call to cancel, or shows up more than 15 minutes late.

Impact of a No-Show Appointment

No-Show appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

- Potentially jeopardizes the health of the "no showing" patient
- Is unfair or frustrating to other patients that would happily take the appointment slot
- Disrespects the time of the physician and staff

When you schedule an office visit with us, we expect you arrive at our practice at least 15 minutes prior to your scheduled appointment. This allows time for our staff to address any insurance or billing questions and/or complete any necessary paperwork before your scheduled visit.

While we ask that you avoid cancelling or rescheduling a scheduled visit with less than 24 hours' notice, we do realize that things come up. In this situation, we still ask that you contact our office as soon as you realize that you need to cancel or reschedule. **It is always better to call rather than "no-show/no-call".**

Consequences of "No-Show" appointments

- A patient with 2 no shows in the previous 12 months, may not schedule a future appointment until they consult with the clinic manager.
- If a patient has more than 2 no-show visits they are subject to termination from the practice at the provider's discretion.

I have read and understand ALEVEA Mental Health "No-Show" Policy as described above.

SIGN HERE

Patients Signature _____ Date _____

ALEVEA
MENTAL HEALTH

Psychotropic Medication Consent

- The nature of my mental condition and the reasons for prescribing the specific medication(s) have been explained to me in terms I understand.
- Alternative treatments and their benefits and disadvantages have been explained to me.
- The type of medication, the dosage, the range of frequency, the route of administration (oral/IM), and the anticipated length of treatment have been explained to me.
- I understand and accept the possible side effects of the following specific types of psychotropic medications which may include, but are not limited to: dizziness, drowsiness, rigidity of muscles, tremors, and dependence. Benzodiazepine: unsteadiness of gait, physical dependence, after prolonged use should be withdrawn gradually, and should not be taken while taking any opiate medications. Antidepressants: decreased appetite, diarrhea, headache, insomnia, nausea, and nervousness. Atypical antipsychotics: decreased coordination and inflammation of the nasal mucous membrane.
- I understand and accept additional possible side effects that may occur when psychotropic medications are taken for extended periods (over three months) include persistent, involuntary movements of the face, mouth, or extremities (hands/feet). These symptoms are potentially irreversible and may appear after the medications have been discontinued.
- I understand psychotropic medication therapy may include lab tests on a regular required basis.
- I have informed the doctor of all my known allergies.
- I have informed all medications I am currently taking, including prescriptions, over-the-counter, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.
- I have been advised whether I should avoid drinking alcoholic beverages and consuming any or all of these medications while taking the psychotropic medication(s).
- I am aware and accept that no guarantees about the results of the treatment have been made.
- I have been advised of the probable consequences of declining recommended therapies.
- The doctor has answered all of my questions regarding this treatment. I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature. I authorize and direct Michael Vines, MD, Christopher (Topher) Bradshaw, PA-C, and Thomas Pearson, PA-C to provide treatment with the following psychotropic medication(s) listed here and/or in the electronic record:

Patient signature _____ Date/Time _____

Print Patient (or guardian/relationship) _____

Witness Signature _____ Date/Time _____

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed treatment to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative fully understands what I have explained.

Thomas Pearson, PA-C / Christopher (Topher) Bradshaw, PA-C _____ Date/Time _____

ALEVEA
MENTAL HEALTH

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Alevea Mental Health's Notice of Privacy Practices effective 12/18/2017

Name: _____ Date: _____

Signature: _____ SIGN HERE

I am a parent or legal guardian of _____(patient name).
I have received a copy of Alevea Mental Health's Notice of Privacy Practices effective 12/18/2017

Name (please print): _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____

Office Use Only

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective 12/18/2017 given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ Email _____
☐ Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____