ASCEND POLYWELLNESS CENTER, LLC

OUTPATIENT MENTAL HEALTH CLINIC

CONSENT TO TREATMENT AND POLICIES

Payment Is Due at Time of Service: All co-pays, coinsurance or deductibles must be paid the day prior to your scheduled appointment. Balances owed from previous visits are expected to be paid in full. If a parent or another party takes responsibility for payment, the patient is still required to bring that payment to the appointment. **We accept Cash, Checks, Money Orders and Credit Cards. THERE WILL BE A $3 TRANSACTION FEE ON ALL CREDIT/DEBIT CARD TRANSACTIONS**. ***Initials***_____

Cancellations: When an appointment is scheduled, that time is reserved for you. A $60 fee will be charged for failure to cancel within 24hrs. Our answering machine is available to relay cancellations when the Office is closed. Emergencies may be excluded from this charge at the discretion of the Office Manager. **The $60 fee is also charged for No-Shows (not appearing for a scheduled appointment). NO EXCEPTIONS.** ***Initials***_____

Emergency Calls: If you are calling weekdays after 5:30PM or on the weekend, you will reach our answering machine. **If you are experiencing an emergency, please hang up and contact crisis intervention or 911**. If your call is not an emergency, please leave a detailed message expressing the nature of your call and someone will return your call the next business day. If you want your therapist/doctor/Provider to know that you are running late or unable to attend an appointment scheduled for that evening, please leave a message and our staff will periodically check our answering machine and notify your therapist/doctor/provider as soon as possible. ***Initials***_____

Mandatory Check-Out at The Front Window: All Patients are required to check out at the front window to schedule an appointment for follow-up visits with your preferred provider. We realize this may result in having a line at the front window and will make every effort to minimize your wait time. We ask that you wait patiently and be respectful of the confidentiality of others in line. ***Initials***_____

Scheduling Appointments: Patients are responsible for scheduling their own appointments and keeping track of their treatment plan. Failure to consistently follow plan of care will result in removal from

schedule. Patients with two (2) consecutive cancellations will be discharged. **NO EXCEPTIONS.** ***Initials*** _____

Same-day Appointments: Same-day appointments are not guaranteed and are only available if there is an opening. Appointments are available on a first come, first serve basis. ***Initials***_____

Insurance Benefits and Billing: Health insurance is a contract between you and your insurance company. For those companies with which we participate, we will file claims as a courtesy to our patients. However, *we cannot bill your insurance unless you provide a copy of your insurance card/virtual card and ID.* We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, coinsurance, covered charges, secondary insurance, etc., other than to supply information as necessary.

If you choose to use your insurance benefits **YOU are responsible for calling your insurance company to obtain co-pay, deductible, and benefit information.**

If you have an overpayment on your account, it will be credited to future visits.

It is your responsibility to be aware of your plan's annual visit limits, deductible amounts, percentage of charges your insurance will pay, and non-covered services. If requested, you will be provided with an invoice for services that contain all information necessary for you to bill your claims.

VA Patients: **ARE REQUIRED TO PROVIDE THEIR FULL SSN FOR BILLING PURPOSES ONLY.** ***Initials***__

Minor Patients: In the case of divorced or separated parents, the person accompanying the child/children is responsible for payment at the time of service. If there is a court order in effect and payment is not made in advance by the party responsible per the court order, payment must be made at the time of service by the adult accompanying the minor and reimbursement will be the responsibility of the parties involved. ***Initials***_____

Lost or Misplaced Prescriptions: Due to increasing administration cost, there will be a $20 fee for lost or misplaced prescriptions. We will **NOT** rewrite lost or misplaced controlled substance prescriptions. **NO EXCEPTIONS. Initials**_____

Prescription Refills: Prescription refills can only be fulfilled during regular business hours, 9am-

6:00pm Monday through Friday. We will **NOT** accept refill requests on weekends or after business hours. Patients who have not been seen in over 30 days, must see a provider to receive refills or change medications. **NO EXCEPTIONS.** ***Initials***_____

Medical Records, Letters and Completion of forms: APWC charges a fee for medical records, letters and completion of forms which varies from $25 to $200 based on complexity. Please allow one week from the date the request was made for the information to be available. ***Initials***

Termination of the Physician or therapist Client Relationship: If you have **NOT** been treated by your preferred provider in 3 months or longer, you are no longer considered a patient, therefore no request for forms, documents or prescriptions will be honored. **To resume treatment a new intake must be completed**. If you miss two (2) consecutive appointments **without notice, you will be discharged from APWC. Initials**_____

I CONSENT TO RECEIVE OUTPATIENT MENTAL HEALTH TREATMENT AT ASCEND POLYWELLNESS CENTER, LLC. INCLUDING PSYCHIATRIC EVALUATION, INDIVIDUAL, GROUP, FAMILY COUNSELING AS WELL AS MEDICATION MANAGEMENT.

This is to certify that I have read and understand this document.

_____ _____

Signature of Responsible Party Date

_____

Print Name

ASCEND POLYWELLNESS CENTER, LLC

CONSENT FOR TREATMENT

Client's Name: _____ DOB:_____

Ascend Polywellness Center, LLC (APWC) is an outpatient mental health clinic. We provide individual, family and group counseling, medication management and mental health evaluations.

Treatment Agreement:

I agree to participate with Ascend Polywellness Center, LLC, and I understand that this treatment will be for me/my child's mental health and physical welfare. I understand that I have the right to have any medication or prescription recommendations explained to me in full and that I have the right to review medications with my psychiatrist or nurse representative.

I understand that I have the right to ethical and fair treatment without regard to my race, religion, ethnic origin, sexual orientation or color. I understand that I have the right to appeal any decision made in my/my child's treatment by first discussing it with my primary doctor or physician. I understand that if I am not satisfied with the determination of this appeal, I may then appeal to the Program Director. I understand that I may refuse treatment within 48 hours' notice. I understand that if I choose to refuse treatment or to rescind this agreement for treatment with APWC, against medical advice, I will not hold APWC accountable for any pain or suffering I/ my child may incur as a result of that refusal or cessation of treatment. I have been given a copy of Patient Rights Policy, Grievance Process and Discharge Policy for my review.

_____ _____ _____

Client/Parent/Guardian signature Relationship to Client Date

_____ _____

APWC LLC Staff Signature Date

ASCEND POLYWELLNESS CENTER, LLC

RELEASE OF INFORMATION

Consumer's Name: _____DOB:_____

The confidentiality of Patients' records maintained by Ascend Polywellness Center, LLC is protected by Federal Law and regulations. The program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as a mental health or drug and alcohol substance abusing patient unless:

1. The patient consents in writing.
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in medical emergency or qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by this program is a crime. Suspected violations will be reported to appropriate authorities in accordance with Federal regulations.

Federal laws and regulations do not protect any information about a crime committed, or threat to commit crimes by a patient either at the program or against any person who works for APWC.

I _____have received and understand the above notice concerning my confidentiality rights at APWC. I have also received a copy of this notice.

_____ _____ _____

Client/Parent/Guardian signature Relationship to Client Date

_____ _____

APWC Staff Signature Date