Consent and Agreement for Psychiatric Mental Health Nurse Practitioner Treatment – Board Certified (PMHNP-BC), & Rights Disclosure - Adult

Groff & Associates, LLC is committed to provide quality, professional healthcare to all of our clients. The treatment information is handled with the utmost care to ensure privacy. This document is for consent and agreement for clinical treatment, integrative healthcare, and to understand client rights and the Agency's rights.

I, _____, hereby attest that I have voluntarily entered into treatment and give my
(Client's First and Last Name)
consent for myself at Groff & Associates, LLC, hereby referred to as the "Agency". Further, I consent and agree to have treatment provided by the Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC), who I acknowledge, understand, and agree, is an independent contractor of Groff & Associates, LLC, and acts pursuant to his or her own professional license and professional judgment, which is not subject to the judgment or control of Groff & Associates, LLC.

Any person providing services is a third party beneficiary to this agreement and may enforce any rights hereunder. The rights, risks and benefits associated with the treatment have been explained to me. I understand I will be given **Addendum PMHNP-BC-Adult**, and I will have the opportunity to ask any questions regarding the informed consent and will have all of my questions, if any, addressed. I also hereby understand, agree, and warrant, that I will meet and discuss the treatment and risks of treatment with the Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC), and provide written consent for the healthcare prior to the start of my treatment. I understand that treatment may be discontinued at any time by either party when not prohibited by applicable professional standards. The Agency encourages that this decision be discussed with the Psychiatric Mental Health Nurse Practitioner (PMHNP-BC). This will help facilitate a more appropriate plan for discharge.

Non-Voluntary Discharge from Treatment: I acknowledge I may be terminated from the Agency non-voluntarily if:

A) I exhibit any physical violence, verbal abuse, carry weapons, or engage in illegal acts at the Agency and/or,
B) I refuse to comply with stipulated program rules, refuse to comply with treatment recommendations, do not provide the appropriate forms upon initial treatment, or do not make payment or payment arrangements in a timely manner and/or,
C) I do not attend my scheduled appointment for two (2) consecutive sessions without notifying the Agency twenty-four (24) hours prior to the scheduled appointment indicating I am able to attend the appointment.

I acknowledge I will be notified of the non-voluntary discharge immediately.

Client Notice of Confidentiality: The client record ("designated record set") and all subsequent or additional protected health information maintained by the Agency is protected by Federal and/or State laws and regulations. Generally, the Agency may not disclose to a person outside the Agency that I attended treatment or disclose any information identifying myself as an alcohol or drug abuser unless:

A) I consent in writing and/or,
B) The disclosure is allowed by a court order and/or,

C) The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, program evaluation, or for the purposes for supervision with the collaborative physician. The disclosure is otherwise permitted or required pursuant to HIPAA and our policies and procedures.

Federal and/or State laws and regulations concerning confidentiality do not generally protect or restrict information about a crime committed by a person, including a client, either at the Agency, against any person who works for the program, or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child, vulnerable adult abuse, or neglect from being reported under Federal and/or State laws to appropriate State or Local authorities. In addition, there are laws and standards, which can require such disclosures under certain circumstances.

Clinicians and other health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Agency's duty to warn any potential victim, when a significant threat of harm has been made. In the event of my death, my spouse or my child(ren)'s parent or legal guardian may have a right to access my records.

Professional misconduct by a clinician must be reported by other clinicians, in which case related client records may be released to substantiate disciplinary concerns. Legal custodial parents or legal guardians of non-emancipated minor clients may have the right to access my records.

Third-Party Payer Rights: In order for the Agency to contact the applicable insurance company on behalf of my clinician, this consent must be signed by me to enable the Agency pre-authorization to request eligibility and benefit information, to file any insurance claim or process necessary paperwork. Client data of clinical outcomes may be used for program evaluation or with your insurance company, but Protected Health Information (PHI) as stipulated by the Department of Health and Human Services will not be disclosed to any outside sources without an **Authorization To Release Information** form, except as permitted or required.

I hereby consent to the disclosure of client records to any listed third-party payer for the purpose of receiving payment reimbursement. This includes a health insurance company and Employee Assistance Program (EAP) providers. The Agency is not responsible for any client disclosure (i.e. diagnostic information, date of service, billing information, etc.) from a health insurance company to the primary insured.

Disclaimers and Limitations of Liability: I understand, agree, and conclusively stipulate that Agency does not direct or control the services provided by its independent contractors, has no duty to direct, control, supervise, or train its independent contractors, and Agency is not responsible for the acts or omissions of its independent contractors. ll independent contractors are properly licensed and insured, and are employees of their own independent legal entities. It is expressly understood and agreed that the Agency's liability is limited to the fees paid for services and in no event will the Agency be liable for any special, incidental, consequential, or indirect damages. It is intended this limitation apply to any and all liability or cause of action however alleged or arising, unless otherwise prohibited by law, including but not limited to negligence, breach of contract, or any other claim whatsoever.

Missed Appointments and Cancellations: I understand if I'm unable to keep a scheduled appointment with my health care provider, I understand a twenty-four (24) hour advance notification is required by either calling my health care provider directly or the business office at (317) 474-6448 x102. If this notice is not given, the **FULL SESSION FEE** will be charged for late cancellations or missed appointments.

Payment Due at Time of Service: I hereby acknowledge that all fees are due at the time of service and are to be made payable to: Groff & Associates, LLC. Payment can be made by either by: check, cash, authorized credit/debit card, or HSA insurance card. The Agency is not responsible for any HSA insurance card that doesn't approve my clinical treatment. As such, any declined HSA insurance card is my responsibility and I must provide another form of payment at the time of service. Any nonsufficient funds (NSF) received via a check or bank/debit card will result in a fee of Thirty-Dollars ($30.00). When appointment fees are not paid in a timely manner, I understand a collection agency may be given appropriate billing and financial information about me, but will not receive any clinical information. If my insurance company doesn't provide financial reimbursement for my treatment or is cancelled at any time during treatment, I am responsible for any of the outstanding balance.

Direction to Disclose My Protected Health Information: I hereby direct the Agency to disclose my protected health information directly with the following individuals who are involved in my care, and I direct that it is in my best interest to do so:

_____

_____

_____

My signature below indicates that I understand the rights of this Agency and acknowledge I have read and understand the Notice of Privacy Practices form. I hereby consent to treatment and agree to abide by the above stated policies and agreements with the Agency.

_____ _____

Signature of Client or Legal Representative **Printed Name of Client or Legal Representative**

_____ _____

Printed Name of Person under Legal Guardianship **Date**

