General Consent for Care and Treatment

Consent to Services: I voluntarily request a health care provider to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at Dera Health. I understand that if additional testing or procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I understand if I am referred to outside agency/facility, it is my responsibility to follow-up for management of medical care/services to prevent complications of symptoms or diagnosed disorder

Patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether 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, 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.

Treatment Compliance: After 3 repeated absences/failure to participate in services may result in discontinuation of services. If you are not scheduling sessions and/or arriving for sessions for a continuous period, we will assume you are voluntarily terminating services with us. After 6 months, you will be required to participate in another intake and assessment process.

Cause for Termination: If it is deemed that the services we provide are not beneficial for you, a decision could be made to discontinue services. Disorderly Conduct, Threatening Behavior, and/or failure to treat other clients and staff with respect can result in discharge from our services. Failure to maintain the confidentiality of others accessing services can result in discontinuation of services. Dera Health reserves the right to discharge clients for reasons not mentioned in this informed consent, should the need arise. Such dismissal from services would not happen without justifiable cause.

Emergency Contact: Please provide contact information for individuals we may contact on your behalf.

Name: ____ Phone Number: ____________________
Relationship to Patient: ____
Name: ____ Phone Number: ____________________
Relationship to Patient: ____

I have read and understand all conditions set forth in this Informed Consent. I consent to participate in Dera Health Mental Health Services.

I certify that I have read, fully understand and agree with the conditions set forth in the Informed Consent and consent fully and voluntarily to its contents. I agree to allow my minor child (name of minor) to participate in Dera Health Services.

Client/Parent Signature____Date______________
Witness Signature ____Date______________

Expiration of Consent: This consent will expire at the time of discharge from behavioral health services from Dera Health LLC

Informed Consent For Telemedicine Services

Patient Name:________________________________ **Date of Birth:**____________ **Today's Date:**__________
Practitioner Name: ☐ Benita Martin
☐ Esther Iwuoha
☐ Other Staff
☐ Other Staff: ______________________________

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or
- allergic reaction or other judgment error

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that if I am in such mental or emotional condition to be a danger to myself or others, my physician has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.
3. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
4. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
5. I understand that it is my duty to inform Dera Health of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
7. My practitioner will respond to communications and routine messages within 48-72 hours on business days or on the next business day following weekends, holidays, or vacations.
8. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.
9. The laws and professional standards that apply to in-person outpatient services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.
10. I attest that I am a resident and or located in the state of ____________________ and will be present in the state of ____________________during all telehealth encounters with Dera Health Practitioners.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Dera Health LLC to use telemedicine in the course of my diagnosis and treatment.

____ ____________________

Patient's Signature **Date**
(Or Authorized Person To Sign For Patient)

____

If Authorized Signer, Relationship To Patient

____

Physician's/Practitioners Signature

Telemedicine Protocol for Dera Health

Service: Telemedicine/Telepsychiatry services are provided by the practitioners at Dera Health, from a distant site equipped with a secure two-way, real time interactive telecommunication system (Doximity/Zoom) to a member in a qualifying originating site i.e. home (Resident of ____________________ State).

Provider: Dera Health Treatment Team; Physician/Family Nurse Practitioner, Psychiatrist and/or Psychiatric Mental Health Nurse Practitioner, licensed professional counselors, licensed social workers, substance abuse counselors and physician assistants

Provider Location: Primarily at Dera Health is virtual. Access will be done through Doximity/Zoom.

Eligible Medical Services: Services that are eligible for reimbursement include consultation, office visits, individual and family psychotherapy and pharmacologic management delivered via a telecommunications system. The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual/family psychotherapy and pharmacologic management.

Services: Telemedicine/Telehealth clinicians at Dera Health will provide a full range of medical and psychiatric services via teleconferencing technology to patients, including assessment, screening, diagnosis, medication management, management of chronic conditions and acute conditions, psychotherapy and treatment of patients and determining the degree of disabilities in patients. The Physician and/or Family Nurse Practitioner, Psychiatrist and/or Psychiatric Mental Health Nurse Practitioner will be providing medical and psychiatric interventions including monitoring and management of their psychiatric or medical condition to include medication management. The psychiatrist, psychiatric mental health nurse practitioner, licensed professional counselors, licensed social workers, substance abuse counselors and physician assistants will provide supportive psychotherapy and psychoeducation about diagnosis, possible comorbidities, prognosis including, treatment plan/options and possible complications of the disease, and psychiatric interventions.

Psychiatrist and/or Psychiatric Mental Health Nurse Practitioner will prescribe medication to patients as deemed necessary and will conduct periodic medication management and re-evaluations as deemed necessary. Additional services include the prescription, direction, and administration of psychotherapeutic treatments or medications to treat mental, emotional, or behavioral disorders, and if necessary ongoing collaboration with physicians, psychologists, social workers, psychiatric nurses, or other professionals to discuss treatment plans and progress.

Provider and Facility Guidelines: The Physicians, Family Nurse Practitioner, Psychiatrist, Psychiatric Mental Health Nurse Practitioner, Physician Assistant, Licensed social workers, licensed professional counselors, substance abuse counselors, and physician assistants will practice within the scope of their specialty and practice within the standard of care for their area.

Assessment and diagnosis, psychotherapy and medication management should be consistent with generally accepted standards of practice for the treatment of the identified behavioral health condition.

Platform: The telemedicine/telepsychiatry program will be using Doximity/Zoom which is a HIPAA Compliant software services and solutions for video conferencing with patients. Patients will be invited by their designated providers to Doximity/Zoom account to conduct video conferencing during the patient scheduled appointment.

Reimbursement for Telemedicine/Telepsychiatry

Telepsychiatry is covered by some health insurances, however please note that if your insurance does not cover this service, patients will be required to pay the full fee for service.

Agreement Of Financial Responsibility: All patients will be required to sign an agreement of financial responsibility as patients will be responsible for all payments owed to Dera Health LLC for services rendered to them. Please note that patient is responsible for all copay, coinsurance and deductible amounts owed to practitioner(s) at the time service is rendered.

FEE SCHEDULE FOR TELEMEDICINE/TELEPSYCHIATRY:
Psychiatric diagnostic interview examination 90972 – $200.00-$350.00 (50 Minutes)
Medical diagnostic interview and examination 99204-99205– $200.00-$350.00 (50 Minutes)
Outpatient Telehealth Pharmacologic Management –99213 GT-$80.00-$150.00 (15 min)
Outpatient Telehealth Pharmacologic Management –99214 GT-$125.00-$200.00 (25 min)
Individual Psychotherapy – 90837 - $150.00-$250.00 (53 min+)

Patient Signature: ___________________________________ Date: _______________

No Surprises Disclosure

In compliance with the No Surprises Act that went into effect January 1, 2022, there is now a Federal requirement for Health Care Providers to inform all healthcare consumers of their Federal rights and protections against "surprise billing".

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by a NON-PARTICIPATING/OUT OF NETWORK healthcare provider. This allows the option for consumers to make the choice to receive care from an in-network provider if one is available.

Additionally, there is a requirement to provide all healthcare consumers with a Good Faith Estimate (GFE) of the cost of services for the duration of treatment. It is difficult to determine the actual length of treatment for mental health care; therefore, the estimate is based on the average length of treatment.

There is also a list of fees that you may incur throughout your care at Dera Health that are in addition to direct counseling services and fees. These fees may occur due to the following (not an exhaustive list):

Late cancellation(anytime AFTER 24 HOURS)/Fail to Show fee: $50.00

Medical records request: $30.00

Completion of documents (FMLA, Disability, VA or other medical summary letters, etc): $25.00

Urine Drug Screen- $25.00

Please note our fees are reviewed biannually, you will be notified in advance of any changes. Consultation hourly fees includes billing for preparation time for meetings/appearances.

If you have any questions, you can contact our main office at the number listed above in this document. If you believe your rights as a health consumer have been violated, and you cannot come to an agreement with Dera Health, you can contact the Department of Health and Human Services at 1-877-696-6775 or www.cms.gov/nosurprises.

By signing, you are agreeing that you understand your Federal health consumer rights, and you understand the fee agreements in this document.

INSURANCE PAYMENT OPTIONS AND FEES

It is the client's responsibility to ensure that all services are paid in a timely manner. The current regular fee for assessment services is $200 for a psychiatric evaluation; medication management follow-ups range between $75-95 and individual therapy services are $65 for 30 minutes sessions and $100 for 45 minutes-1 hour. For clients who have insurance, there are specific contract rates, deductibles, copays and/or coinsurance amounts, and if you don't know the specifics of your policy, please contact your insurance carrier. There are additional non-clinical fees for reports and other documentation completion that are not covered by insurance, and they are the sole financial responsibility of the client. All co-pays, co-insurance, and deductibles are due at the time of service.

Cancellations and re-scheduled visits will be subject to a $50 charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time. The standard meeting timeframe is 30-45 minutes.

Late cancellation fees are NOT billed to insurance or EAP companies, they are the sole financial responsibility of the client. If you cannot attend an appointment, please remember to cancel or reschedule 24 hours in advance. You will be responsible for the $50 cancellation fee if you cancel your scheduled appointment less than 24 hours of the session. SELF-PAY AND OUT OF NETWORK DISCLOSURE.

In compliance with the No Surprises Act that went into effect January 1, 2022, there is now a Federal requirement for Health Care Providers to inform all healthcare consumers of their Federal rights and protections against "surprise billing".

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by a NON-PARTICIPATING/OUT OF NETWORK healthcare provider. This allows the option for consumers to make the choice to receive care from an in-network provider if one is available.

Additionally, there is a requirement to provide all healthcare consumers with a Good Faith Estimate (GFE) of the cost of services for the duration of treatment. It is difficult to determine the actual length of treatment for mental health care; therefore, the estimate is based on the average length of treatment. More detailed information is included in the Good Faith Disclosure Document

Please note that your information can be securely stored by Athena, a HIPAA compliant Electronic Health Record System.

By signing this document, I agree to the above disclosures as it pertains to my financial account with Dera Health.

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time