Richmond Creative Counseling, LLC

Psychiatric Services Informed Consent

I, _____, (Patient/Legal Guardian) do voluntarily consent to care and treatment by: Lauren Woolfolk, PMHNP-BC, Donna Hayden, PMHNP-BC, and/or Ashley Garcia, PMHNP-BC.

General/Appointments and Fees:

❑ I understand that no guarantees are being made to me as to the results of evaluation or treatment.

❑ I am aware that I am an active participant in this endeavor, and that I share the responsibility for treatment by providing all accurate information about my history, or my child's history.

❑ I understand that our work will be kept confidential with the exception of disclosures required by law and when necessary in connection with my care. In particular, I am aware that, although my Psychiatric Nurse Practitioner (PMHNP) is a clinically independent practitioner, consultations with associates are at times clinically advisable and my signature below gives my PMHNP permission to do that. The associates also provide emergency coverage for each other when one is out of the office, and I understand that an associate providing coverage for my PMHNP may need access to relevant information to provide the best interim care possible. My PMHNP works collaboratively with my therapist when I am in therapy to ensure that everyone is working together to best support my needs.

❑ I authorize the release of any information necessary to process any insurance claims or to help get preauthorization for visits and/or medications.

❑ I am aware that there is no charge for brief telephone calls, however calls regarding treatment or medication issues lasting more than 5-10 minutes will be pro-rated and billed at the regular hourly rate ($330).

❑ I understand that if I arrive more than 5 minutes late for my appointment, I may not be able to be seen that day. Please arrive a few minutes early for your appointment to check-in.

❑ I am aware that all balances must be paid prior to scheduling my next appointment. This includes billed charges such as those for no shows, late cancelations, completion of forms/letters, phone calls, etc.

❑ I understand that I will be charged additional fees for the following services:

- *Professional Forms*: completion of forms for employment, school, return-to-work, disability, retirement, legal action, etc. Forms can take up to 10 business days to complete from the time of the request and fees are pro-rated at the hourly rate of $330.
- *Letters*: incur a pro-rated hourly fee of $330, billable in 15 minute increments and payment is due prior to completion of the letter. This includes, but is not limited to, forms pertaining to insurance, employment, return-to-work status, school, disability, retirement, and legal action. Letters may take up to10 business days to complete from the time of the request.
- *Medical Records*: are provided at a rate of $0.50 for the first 50 pages and $0.25 for each additional page, $10.00 flat fee, plus any postage costs if the records must be mailed. Medical records can take up to 10 business days to complete from the time of the request. All requests for copies of medical records must be received in writing, dated and signed, and must include a reasonable description of the records sought.
- *Subpoena for Witness*: If my PMHNP is subpoenaed for court, the fee is $430 per hour, plus additional fees (see RCC Court Appearance Policy).
- *Refill Requests Between Appointments*: A $15 fee will be incurred for refill requests that occur when an appointment has been missed or canceled by the patient.

Medication Rules:

❑ I am aware that my PMHNP, or her support staff, will make every effort to return calls within 72 business hours. See Emergency Policy below.

❑ I understand that my PMHNP participates in the Prescription Monitoring Program and, by law, may access information about me and/or report information about me, as applicable.

❑ I understand that my PMHNP participates in systems cooperation with other community entities- to include but not limited to- other providers/health systems/laboratories/pharmacies, etc., and may access information about me, as applicable to my care.

❑ I understand that my PMHNP must be informed if I am receiving, or plan to receive, psychiatric medication management from another provider. My PMHNP is happy to coordinate a transition to a new provider if/when I choose to make a change.

❑ I understand that it may take up to 72 business hours for a refill request to be completed and that there is no guarantee that my PMHNP will approve the request between appointments. If approved, a $15 fee will be applied (see fee information on reverse side).

❑ Some Schedule IV medications will not be authorized to fill early. Please discuss this with your PMHNP.

❑ Controlled substances may require a hard copy prescription and will not be authorized to fill early.

❑ Unless approved by my PMHNP, no changes to medication will be made outside of scheduled appointments.

❑ I may only request a medication refill once before attending my next appointment and must allow for up to a 72 hour turnaround.

❑ Medication changes, refill requests, and questions concerning your medication will not be addressed on evenings or weekends, but will be handled the following business day within a 72 business hour timeframe. Please refer to the emergency protocol.

❑ Please plan ahead and schedule an appointment prior to running out of your medication. Refills may not be filled, but every effort will be made to schedule you as soon as possible upon your appointment request.

❑ I understand that if I no show or late cancel for my appointment and require medications, no changes will be made and medications will be refilled for 7 days only until I have an appointment scheduled.

❑ I understand that if I have not attended an appointment for more than 7 months, my medications will not be refilled. I will be scheduled for a new intake at the discretion of my PMHNP.

❑ If I am terminated for any reason from Richmond Creative Counseling, a 30-day supply of most medications will be provided to me at my PMHNP's discretion.

Emergency Policy:

If you are experiencing a psychiatric emergency, a life threatening emergency, and/or medication side effects causing shortness of breath, heart problems, severe rash, or other life-threatening concerns, please call 911 or go to your nearest emergency room. While the PMHNP or her support staff may be able to contact your medical provider regarding medication emergencies during established business hours, this is not guaranteed outside of normal business hours. Medication management is managed during regular business hours only, when your PMHNP is in the office. Phone calls will be returned within 72 business hours.

Patient Rights/Discharge:

Non-voluntary discharge from treatment: A patient may be terminated via a non-voluntary discharge letter if: (A) the patient exhibits physical violence, physical or emotional intimidation, verbal abuse of any kind, and/or patients or family members carry weapons or engage in illegal acts of any kind. Abusive messages or phone correspondence may also be grounds for non-voluntary discharge. (B) The patient refuses to comply with stipulated clinic rules, refuses to comply with treatment plans/recommendations, or does not make a payment and/or payment arrangements in a timely manner. (C) The patient repeatedly cancels, late cancels, or no shows for appointments. A patient may choose to terminate treatment at any time of their own accord and a 30 day supply of most medications will be provided with some exceptions (to be discussed with your PMHNP).

❑ Richmond Creative Counseling, LLC has provided me with a copy of Notice of Privacy Practices and all of my questions have been answered.

I have the right to revoke this consent in writing and terminate services with my Psychiatric Nurse Practitioner at any time.

1. "I have read and understand the information on this sheet. My signature below indicates my informed consent with Lauren Woolfolk, PMHNP-BC, Donna Hayden, PMHNP-BC, or Ashley Garcia, PMHNP-BC."
2. It is helpful that we make contact with your Primary Care Physician (PCP) and your therapist or other providers (if applicable) to coordinate your care. If you object to this, please indicate below and this will be discussed in your first session.
   _____ Yes, I consent to sharing information with my other providers.
   _____ No, do not share information at this time.

3. An E-mail and text reminder is automatically provided if you offer your E-mail address and phone number. If you prefer a phone call reminder, please indicate below.

   _____ E-mail @ _____
   _____ Phone @ _____
   _____ No contact preferred

_____ _____
Signature of Person Agreeing to Treatment Date

_____
Signature of Legal Guardian