Client Information and Consent

Welcome and thank you for considering Carnelia Mental Health LLC ("Company", "us") for your mental health needs. This document contains important information about our professional services and business policies.

Mental Health Services

The undersigned professional is a licensed healthcare professional. The mental health professional is engaged in private practice providing mental health care services to clients through the Company or via licensed agents of the Company. As an agent of the Company, your mental health professional provides all mental health services through the Company and not personally.

While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. The mental health professional, using their knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches for change to occur.

Appointments

Follow up appointments are made by visiting https://carneliamentalhealth.clientsecure.me. Please call to cancel or reschedule at least 24 hours in advance, or you may be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments. If you are late, you will be charged for the full amount of the appointment and there will be no pro-rating of the fee. If the mental health professional has to cancel the appointment, you will be entitled to a refund.

Number of Visits

The number of sessions needed depends on many factors and will be discussed by the mental health professional. Your initial session will involve an evaluation of your needs and depending on your circumstances further evaluative sessions may be required. At the end of the evaluation process the assigned mental health professional will be able to provide you with some first impressions of what mental health services may include and a treatment plan to follow if both you and mental health professional agree to work together. You should evaluate this information along with your own opinions of whether you feel comfortable working with the mental health

professional. Mental health services involve a large commitment of time, money, and energy, so you should be very careful about the mental health professional you select. If you have questions about procedures feel free to discuss them with the mental health professional at any time. If you have doubts your mental health professional will be happy to help you set up a meeting with another mental health professional for a second opinion.

Length of Visits

The initial intake and evaluative session is normally scheduled for sixty (60) minutes and may run longer depending on the testing or assessments a client is asked to complete. Further evaluative sessions may be scheduled as needed for the mental health professional to accurately assess your needs. Once the evaluation process is completed sessions are 45-60 minutes in length.

Relationship

Your relationship with the mental health professional is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the mental health professional not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The mental health professional cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you.

If the mental health professional encounters you in a public setting, in order not to reveal your identity the mental health professional will not acknowledge your presence unless addressed by you first.

Gifts, bartering, and trading services are not appropriate and should not be shared between you and the mental health professional.

Payment for Services

The fees for our services are listed below (or attached on a fee schedule):

Diagnostic Evaluation (90791) - $250

60 Minute Therapy Session (90837) - $200

45 Minute Therapy Session (90834) - $170

30 Minute Therapy Session (90832) - $140

60 Minute Couples/Family Session (90847) - $200

60 Minute Family Session without Client Present (90846) - $200

Group Therapy (90853) - $125

Complexity Add On (90785) - $40

Records/Summary Letter - $40

Returned Check - $40

Disputed charge fee - $25

Late Cancel Fee (less than 24 hours notice) - $150

No Show/ Missed Appointment with no notification - $200

Court Preparation and Documentation - $60

Court Appearance - $350 per hour

SPACE Parent Coaching - $200 per hour

Private Pay and Sliding Scale Options Available.

These fees are subject to change upon thirty (30) days' prior notice to you. If you are unable to pay, or are not willing to pay, the higher fee after receipt of notice, services may be terminated, and you may be given referrals to other competent providers. The undersigned mental health professional will look to you for full payment of your account, and you will be responsible for payment of all charges. You are responsible for fees at time of service and balances after insurance including copays, coinsurance and deductibles. You are responsible for understanding your insurance benefits and coverage. Any amount not covered by insurance is your responsibility and must be paid within 30 days of invoice. Failure to provide payment for services within 30 days of invoice may result in balance forwarding to our contracted collections agency.

Although it is the goal of the undersigned mental health professional to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or the mental health professional's testimony are requested by you or required by law, regardless of who is responsible for compelling the production or testimony, you will be responsible for and shall pay the costs involved in producing the records and the hourly rate charged by the mental health professional at the time of the request or service of the subpoena (current rate is $350/hour) for the time involved in traveling to and from the testimony location, reviewing records and preparing to testify, waiting at the location, and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered by the mental health professional. The mental health professional may require a deposit for anticipated court appearances and preparation. You will not be entitled to a pro-rated refund.

Duty to Warn

In the event that the undersigned mental health professional reasonably believes that you are a danger, physically or emotionally, to yourself or another person, by signing this information and consent form below, you specifically consent for the mental health professional to warn the person in danger and to contact any person in position to prevent harm to yourself or another person, in addition to medical and law enforcement personnel.

This information is to be provided at your request for use by said persons only to prevent harm to yourself or another person. This authorization shall expire upon the termination of your mental health services with the undersigned mental health professional.

You acknowledge that you have the right to revoke this authorization in writing at any time to the extent the undersigned mental health professional has not taken action in reliance on this authorization. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned mental health professional that you have received and reviewed.

You acknowledge that you have been advised by the undersigned mental health professional of the potential of the redisclosure of your protected health information by the authorized recipients and that it may not be protected from unauthorized disclosures as required by the federal Privacy Rule.

You further acknowledge that the treatment provided to you by the undersigned mental health professional was not conditioned on you providing this authorization.

Mandated Reporting

Under certain state law, persons in designated professional occupations are mandated to report suspected child abuse or neglect or maltreatment of vulnerable adults. Persons who work with children and families are in a position to help protect children from harm. These persons may be required by law to report, if they know or have a reason to believe that a child or vulnerable adult is being abused or neglected. As a mandated reporter, the mental health professional may be required to break confidentiality and report certain information to the appropriate authorities.

Risks of Mental Health Services and Assumption of Risk

You may learn things about yourself that you do not like. Often growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from mental health services. Specifically, one risk of marital mental health services is the possibility of exercising the divorce or separation option. There are no guarantees in mental health services

and the mental health professional does not make any guarantees with this agreement. You assume the risk of mental health services by signing this form. The mental health professional is not liable for any adverse reactions to mental health services. The mental health professional may take any reasonable action necessary during mental health services when there is a dangerous circumstance, as determined by the mental health professional.

After-Hours Emergencies

Please know that your mental health professional and Company do not provide twenty-four (24) hour crisis or emergency mental health services. Should you experience an emergency necessitating immediate mental health attention, immediately call 911 or if you are able to safely transport yourself, go to the nearest hospital emergency room for assistance.

Contacting Your Mental health professional

Your mental health professional is often not immediately available by telephone or in person. The office number 651-294-6112 is answered by voicemail that the mental health professional will monitor from time to time throughout the day. There is no guarantee of a response time or a response at all. If you are difficult to reach, please inform your mental health professional of times when you will be available. In most circumstances, the appropriate time to discuss any topic outside of rescheduling is at the next session.

E-Mail

The undersigned mental health professional and Company may use and respond to email only to arrange or modify appointments. Please do not send emails related to your treatment or mental health services as electronic communications are not completely secure and confidential. Any mental health services related questions or issues will not be addressed by the mental health professional in any electronic communication but will be dealt with during your next appointment. Any electronic transmissions of information by you are retained in the logs of your service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. You should know that any e-mails, online communications and specifically the website carneliamentalhealth.com are not secure and you assume the risks of the insecure transmission.

Social Media

Your mental health professional does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the mental health professional and the client. It can blur the boundaries of the professional relationship and are not permitted. Any attempt by a client to surreptitiously gain access to the mental health professional's personal site(s) will be cause for termination of the mental health services.

Mental health professional's Incapacity or Death

You acknowledge that, in the event the undersigned mental health professional becomes incapacitated or dies, it will become necessary for another mental health professional to take possession of your file and records for administrative purposes, but not necessarily to become your mental health professional. By signing this information and consent form below, you give consent to allowing another licensed mental health professional selected by the undersigned mental health professional to take possession of your file and records and provide you with copies upon request, or to deliver them to a mental health professional of your choice and also to provide you with simple notifications of updates of the Company transition. The Company will select a successor mental health professional within a reasonable time and will notify the appointed licensed mental health professional.

Colleague Consultation

In keeping with standards of practice, your mental health professional may consult with other mental health professionals regarding care and management of cases. The purpose of this consultation is to ensure quality of care. Your mental health professional will maintain complete confidentiality and protect your identity by not using real names or any identifying information.

Audio and Video Recordings

You acknowledge and, by signing this information and consent form below, agree that neither you nor the undersigned mental health professional will record any part of your sessions unless you and the mental health professional mutually agree in writing that the session may be recorded. You further acknowledge that the undersigned mental health professional objects to you recording any portion of your sessions without the mental health professional's written consent. You expressly agree that audio and video recordings used for security purposes are not part of mental health services, and are therefore not protected by confidentiality or any other provisions under this agreement.

Termination of Relationship

The undersigned mental health professional may set boundaries including forms of client interactions and communication including ceasing to provide services to you for good cause, including without limitation: your refusal to comply with treatment recommendations, the undersigned mental health professional or staff is uncomfortable working with you, or your failure to timely pay fees or deposits in accordance with this Agreement, subject to the professional responsibility requirements to which the undersigned mental health professional is subject. It is further understood and agreed that upon such termination of services of the undersigned mental health professional, any of your deposits remaining in the undersigned mental health professional's account shall be applied to any balance remaining owing to the

undersigned mental health professional for fees and/or expenses and any surplus then remaining shall be refunded to you.

Conflicts of Interest

Mental health professionals avoid conflicts of interest in treating minors or adults involved in custody or visitation actions by NOT performing evaluations for custody, residence, or visitation of the minor. Mental health professionals who treat minors may provide the court or mental health professional performing the evaluation with information about the minor from the mental health professional's perspective as a treating mental health professional, so long as the mental health professional obtains appropriate consents to release information.

Pre-Licensed Mental health practitioner

The Company may make use of a pre-licensed mental health professionals, which are individuals in the mental health field working toward their professional licensure in mental health services under an approved tract allowed by law. This means that the practitioner does not have a license. The practitioner is authorized to provide services while under supervision of a licensed professional. You understand this engagement and you consent to it by signing this Agreement. You have had the opportunity to ask questions about the engagement. You may continue to ask questions or voice concerns at any time. You may request to not have a pre-licensed mental health professional, but this may mean that services are unable to be rendered at the Company.

Legal

This Agreement shall be construed in accordance with, and governed by, the laws of the State of Incorporation of the Company as applied to contracts that are executed and performed entirely in State of Incorporation of the Company. The exclusive venue for any court proceeding based on or arising out of this Agreement shall be the county of the business address of the Company. The parties agree to attempt to resolve any dispute, claim or controversy arising out of or relating to this Agreement by arbitration, which shall be conducted under the then current arbitration procedures of the American Arbitration Association any other procedure upon which the parties may agree. The parties further agree that their respective good faith participation in arbitration is a condition precedent to pursuing any other available legal or equitable remedy, including litigation, arbitration or other dispute resolution procedures. If any legal action or any arbitration or other proceeding is brought for the enforcement of this Agreement, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Agreement, the successful or prevailing party or parties shall be entitled to recover reasonable attorneys' fees and other costs incurred in that action or proceeding, in addition to any other relief to which it or they may be entitled.

Consent to Mental Health Services

I, voluntarily, agree to receive (or agree for my child to receive) Mental Health assessment, care, treatment, or services, and authorize Company to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care (or my child's care), treatment, or services, and that I may stop such care, treatment, or services that I receive (or my child receives) through Company at any time.

By signing this Client Information and Consent form, I, the undersigned client (or parent/guardian), acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

I acknowledge that I received a copy of this signed information and consent form from my mental health professional on the date listed below.

_____ _____

Signature of Patient/Client or Parent 1/Legal Representative *Date*

_____

Relationship to Patient/Client (if applicable)

_____ _____

**Signature of Parent 2/Legal Representative* *Date*

_____

Relationship to Patient/Client (if applicable)

(*Only necessary if client is a minor and parents are separated)

My signature indicates that I am the legal parent or guardian of the above named minor and that I am allowing my child to be treated at the Company in the event of an accident, injury, illness, or other medical condition. I understand that I am responsible for all costs incurred and that an insurance ready bill will be provided for me to submit to my insurance company. I recognize that I have the right to revoke this consent and that this consent is not needed when the above named individual reaches the age of consent or applicable law in my State and meets any of the conditions identified above.

_____ _____

Signature of Parent 1 or Legal Representative *Date*

_____ _____

**Signature of Parent 2 or Legal Representative* *Date*

*(Only if client is a minor and parents are separated)

Parental Waiver of Right to Child's Records [Optional]

I hereby waive my right as parent/guardian to obtain information from and copies of any records from Company pertaining to the assessment, evaluation, and treatment of the my child. I understand that Company may refuse to provide me, or any third party acting upon my request or authorization, with information and records pertaining to this child's mental health evaluation and treatment, if disclosure in the opinion of the child's mental health professional would negatively impact the child or the child's evaluation and treatment. I hereby release Company and its agents from any and all liability for good-faith refusal to disclose the child's information or records.

_____ _____

Signature of Parent 1 or Legal Representative *Date*

_____ _____

Signature of Parent 2 or Legal Representative *Date*

Notice of Privacy Practices &

Consent for Treatment

This notice describes how your medical records and related personal information may be used and disclosed by Carnelia Mental Health LLC and how you are able to access this information. Please review it carefully. This consent form applies to all providers and all locations that I may receive care at through Carnelia Mental Health LLC.

Carnelia Mental Health LLC, is required by law to maintain the privacy of your **protected health information (PHI)**. This document provides you with notice of your privacy rights and the legal duties and privacy practices of your practitioners and Carnelia Mental Health LLC with respect to your PHI. All terms of this notice regarding your PHI will be followed, unless terms are amended or added, to remain in accordance with federal and state law. If this notice changes, you will receive a copy of the revised notice via U.S. mail, to the last address you have provided for this communication purpose, or via email if you have indicated you prefer to receive electronic communication. At any time, you may request a paper copy of this notice, or an amended version, and one will be provided to you.

Understanding Your Protected Health Information

Protected health information is any identifiable patient information that contains:

1) Any information that concerns your health and medical status or personal identifying information;
2) Any information about medical or psychiatric care that has been, is being, or will be delivered to you;
3) Financial information regarding payment for your medical visits and procedures and insurance information; and
4) Any information about genetic testing, results, or information about you or your family members; a request for genetic services; clinical research participation that is related to genetics; or symptoms and/or diagnosis of a genetic disease or condition of either you or your family member(s).

The purpose of creating and storing your medical record is to document your hospital and clinic visits and communications between you and your health care providers. This process allows Carnelia Mental Health LLC to provide informed and quality care to our patients and to remain in compliance with all applicable federal and state laws. Your medical record will contain, among other things, examinations and test or lab results, diagnoses, treatments, visit notes, prescription orders, and a plan for future care or treatment.

Your Health Information Rights

Although your health record is the physical property of Carnelia Mental Health LLC, the information contained in it belongs to you. You have the following privacy rights:

1) The right to request restrictions on the use and disclosure of your PHI to carry out treatment, payment, or health care operations.
   -It is important for you to know that if agreeing to certain requests would negatively affect your care, Carnelia Mental Health LLC reserves the right to deny your request.
   -If you pay out-of-pocket, in full, for a health care or service cost, you may request Carnelia Mental Health LLC to not share that information or the information related to your service with your health insurer, and Carnelia Mental Health LLC will abide, provided there is not a law that requires that information to be shared.

2) The right to ask Carnelia Mental Health LLC to correct health information that you believe to be incorrect or incomplete. Please ask us how to do this. Carnelia Mental Health LLC reserves the right to deny your request, and you will be given notice in writing within 60 days as to why the request was denied. Additionally, if your request is denied, you can speak with your health care provider and request documentation of your request to be included in your health record, along with the denial, and for those documents to be included in any future disclosures of your PHI. Your request for amendment will automatically be denied if the documentation was created by an outside agency.

3) The right to ask us to contact you confidentially. You may specify to us the means in which you would prefer communications (via telephone, U.S. mail, email, etc.), and Carnelia Mental Health LLC will do its best to accommodate this request, within reason.

4) The right to request restrictions on the use and disclosure of your name, location of where you receive treatment or care, your health or medical status, diagnoses, or any other identifying information. You have the right to limit:
   - disclosure to your family and friends;
   - certain disclosures to those involved in your care, unless it would negatively affect the quality of the care you would receive; or
   - in the event of a disaster relief situation.

5) The right to get a list (an "accounting") of those with whom we've shared your health information and why. This information is available to you for up to six years prior to the date you request this list. Not included in this list is:
   - Disclosures you requested Carnelia Mental Health LLC to make to specific individuals or entities.
   - Disclosures done for purposes of payment.
   - Disclosures that are industry practice for health care operations.
   - Disclosures that are mandatory according to federal and state law or for the purposes of maintaining our license with DHS or the Department of Health.

One accounting will be available to you per year at no cost. If you require more than one list in a 12 month span, you may be required to pay a reasonable fee for it.

6) The right to file a complaint if you feel your rights have been violated and Carnelia Mental Health LLC will not retaliate against you if you file a claim.
   You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:
   - sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
   - calling 1-877-696-6775; or
   - visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

7) The right to inspect and copy your PHI, in the presence of a Carnelia Mental Health LLC staff person, unless in the case of psychotherapy notes, if your clinician or treatment team has determined that disclosure to you of the information contained would be detrimental to your physical or mental health, or it is likely to cause you to inflict self-harm or harm to another.
   You may request copies of your PHI by submitting a written request or filling out a release of information form that details your request. Carnelia Mental Health LLC will provide requested documents within a reasonable period, no more than 10 business days. There may be a fee for each page copied.

8) The right to rescind a release of information or authorization to release your PHI to an outside entity or agency. If the information has already been shared with your permission, we cannot take the information back, however, if you have given permission and change your mind, you can rescind the release of information at any time. You may do this by submitting your request in writing.

Carnelia Mental Health LLC's Responsibilities regarding your PHI:

- It is our duty to keep your health information secure, private, and protected.
- It is our duty to notify you if there has been a breach of your health information.
- We will follow the responsibilities and practices laid out in this notice and remain up to date with changes in federal or state law to remain in compliance.
- We will abide by your requests regarding your PHI, within reason, and according to applicable federal and state law.
- We will never share your information without written consent from you for marketing purposes or sale of your information.
- We will make all attempts to ensure your PHI is a thorough and complete representation of the services and treatments you receive with Carnelia Mental Health LLC.

How Carnelia Mental Health LLC may use or disclose your PHI, with your consent (please note that releases of information or written consent that is signed and dated is generally only valid for a period of one year, or less if specified):

- For the purposes of your treatment, payment for services, and the general operations of Carnelia Mental Health LLC.

- When you have requested your medical record, or portions of your medical record, be released to another agency/entity.
- When organ and tissue donation or organ procurement organizations request it.
- For health, medical, or scientific research, provided you do not object to it. If you object, your health information will not be released.
  If you do not object and portions of your health record are released, you may request, and we will provide, information on to whom the health record was released to and the date it was released.
  In most cases, Carnelia Mental Health LLC will not connect your name to health records released for research purposes.

Carnelia Mental Health LLC may share your personal information with public health or other authorized agencies without your consent (under federal and state law) when:

- The disclosure is to a related entity that is affiliated with Carnelia Mental Health LLC and it is related to your treatment.
- The disclosure is to provide health care services in the event of a medical emergency or disaster relief situation.
- There is a substantial barrier to communicating with you and Carnelia Mental Health LLC's medical or clinical staff believe you intend for us to provide care to you.
- Health care services are provided to you as an inmate.
- Carnelia Mental Health LLC is required by law to treat you and we are unable to obtain your consent, despite attempting to do so.
- Carnelia Mental Health LLC is complying with certain government functions such as military, national security, correctional facilities, and presidential protective services.
- It is necessary to protect or reduce a serious threat to someone's health or safety. You will be informed of this disclosure, unless informing you would further put that person's safety or health at risk.
- Suspected abuse or neglect of a child or vulnerable adult is reported.
- Reporting product recalls.
- Preventing or controlling diseases.
- Reporting adverse reactions to medications.
- It is a part of Carnelia Mental Health LLC's oversight activities, such as audits, inspections, or investigations from a government agency.
- It is a part of managing our operations, such as with business partners that we do work with but are not our employees or affiliates. These business partners are required by law to keep your information secure and protected.
- It is required for workers' compensation claims.
- It is necessary to work with a medical examiner or coroner.
- A public health authority is collecting information regarding vital life events, such as birth or death.
- Legal actions require it, such as a court order, grand jury subpoena, warrant, or other legal process or for law enforcement purposes.
- To defend Carnelia Mental Health LLC in a legal action or related proceedings you bring against Carnelia Mental Health LLC.
- Federal or state law requires it.

Special Provisions for PHI Related to Psychotherapy Notes or Substance Use Treatment:

Psychotherapy notes and records related to substance use treatment may be a part of your PHI. These portions of your health record require separate written consent that explicitly states the types of records that will be released or communication that can take place, the purpose of the release, the expiration date, and the person, agency, or entity the records are to be released to.

Mandated Reporting

Under certain State Law, persons in designated professional occupations are mandated to report suspected child abuse or neglect of vulnerable adults. Persons who work with children and families are in a position to help protect children and vulnerable adults from harm. These persons may be required by law to report to authorities if they know or have a reason to believe that a person is being abused or neglected, and this may be done without your consent. Behavioral health personnel may be required to break confidentiality and report certain information to the appropriate authorities.

Medical Power of Attorneys/Durable Power of Attorneys

If you have a health care directive and have appointed a medical power of attorney or a durable power of attorney, this appointed person will have the ability to make medical decisions for you and access your PHI, but only in the case that you become incapacitated or incompetent.

Adults who Have Guardians

If a guardian has been appointed to you through a court order, your guardian has the power to give necessary consent for you to receive medical or professional care and your guardian also has full access to your PHI.

Minors

Minors are persons who are under the age of 18. Parents of certain minor children, who are able to consent for treatment on their own without their parent's involvement, do not have access to their minor child's health record and the release of records or PHI will require written consent from the minor child. The only exception to this is if the health care professional treating the minor believes that failure to inform the minor's parent or guardian would seriously jeopardize the health of the minor patient. Minors who are able to consent for treatment on their own include:

- Minors who live apart or separately from their parents or legal guardians and is managing his or her own financial affairs.
- Minors who are married.
- Minors who are parents to a biological child.
- When the services are to determine the presence of or to treat pregnancy and conditions associated therewith.
- When the services are related to venereal disease(s)/STDs/STIs.

- For Hepatitis B vaccinations.
- When the services are for the assessment or treatment of alcohol or drug abuse.
- Emergency treatment for medical, dental, or other health services if the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would cause a delay in treatment.

Additionally, parents may be deemed to not be personal representatives of their minor child, and therefore have limited or no access to their minor child's PHI if the minor is subject to domestic violence, abuse, neglect, or endangerment and notifying the parent of the minor's PHI may place the minor in further danger.

Cell Phone, Cameras, or Other Recording Devices

It is our duty and responsibility to ensure that your PHI is kept secure and protected; therefore, we prohibit any type of recording or photographs while you are receiving services. Some providers may require additional protection that may necessitate you to surrender your mobile device, or any other type of recording or photography device, while you are actively receiving services. Health care providers may also take action and potentially discharge you from services if confidentiality rules are not abided by in regard to photography or recording.

For information or concerns related to Privacy Practices, please contact Carnelia Mental Health LLC at:

651-294-6112

info@carneliamentalhealth.com

Consent for Treatment

I acknowledge and understand that I have sought out treatment for a physical or behavioral health condition and that I consent to Carnelia Mental Health LLC and its providers providing care for me. The care may include, but is not limited to: management of symptoms, diagnosis, testing, therapy, education, prescriptions, and other various types of treatment. In order to effectively provide me care, I understand that information may need to be gathered, and that this will become a part of my health record with Carnelia Mental Health LLC.

I also understand that I may refuse treatment, or certain types of treatment, at any time, however, refusal may negatively affect my overall outcome of treatment. In health care, there are no guarantees for specific outcomes.

Health Records and Personal Health Information (PHI)

I acknowledge that if there is a particular request I have regarding my PHI, I will make this known to my provider or providers and that they will do their best, within reason, to honor my request.

I also acknowledge that in order for Carnelia Mental Health LLC to release my records or PHI, upon my request, to another person, agency, or entity, it will require me to sign a release of information, that cannot be consented to orally.

If at any time I decide I want to revoke a release of information, I must do so in writing.

Communication

I understand that Carnelia Mental Health LLC may need to contact me to discuss services I have received, financial matters related to billing, and for future appointments or services. I consent that Carnelia Mental Health LLC may contact me (please check the box of which forms of communication you consent to and fill in the contact information):

- □ Email: _____
- □ Home Phone: _____
- □ Cell Phone: _____
- □ Home Address: _____

  _____

Can staff leave a message on your phone regarding upcoming appointments?

- □ Yes
- □ No

Health Records for Research Purposes

Medical research is a fundamental way for health care and health care treatments to evolve and improve. My health records, if I consent, will always be handled according to all applicable federal and state privacy laws, and many times, my name will not be connected to the information released from my health record.

- □ I have checked this box because I **do not consent** to my health records to be used for research purposes.

Consent to Communicate with Insurance

I acknowledge and understand that Carnelia Mental Health LLC will need to release my PHI for purposes of billing, claims, and payment for the services I receive.

I also acknowledge that it is my responsibility to submit all insurance information to Carnelia Mental Health LLC and to contact my insurance company to inquire about coverage for the providers I may see and the services I may receive.

Privacy Practices Notice and Client Consent Form

By signing this form, I acknowledge that I have been given an opportunity to review the Privacy Practices and Client Consent, have received a copy if I requested one, that I understand the information presented, and I agree to the provisions contained in this form. If I have questions or concerns, I will speak to my provider or an appointed person with Carnelia Mental Health LLC. I understand that this form is valid until revoked by me in writing.

_____ _____

Signature of Patient/Client or Legal Representative *Date*

_____

Relationship to Patient/Client (if applicable)

Carnelia Mental Health LLC I P: 651 294 6112 I F: 651 294 6715
7300 W. 147th Street Suite 215 Apple Valley MN 55124
www.carneliamentalhealth.com