Urgent Behavioral Health Care

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CONSENT AND AGREEMENT FOR TREATMENT

Please read the following information carefully. After you have read this Consent and Agreement, please sign your name below to accept the terms of this agreement. ***Please initial next to each item.***

_____ 1. ***Consent to treat:*** As a consenting adult, I agree to permit the psychiatrists, nurse practitioners and therapists at Urgent Behavioral Health Care (UBHC) to provide psychiatric evaluation, medication management, individual and/or family counseling.

_____ 2. ***Emergency care:*** UBHC staff are available by phone 24 hours a day to take emergency calls. Urgent appointments are available within 24-48 hours. Scheduling routine follow up appointments are not considered an emergency.

_____ 3. ***Medications:*** Prescriptions are generally written in a quantity to last until the next scheduled appointment. It is our policy to **NOT** refill prescriptions outside of scheduled appointments. If you cancel or miss an appointment, we will reschedule you ASAP to see a clinic provider to receive a new prescription. Lost or stolen prescriptions for controlled substances will **NOT** be replaced. Medications are not routinely changed over the phone; you will need to make an appointment if you are requesting any medication changes. Certain medications require prior authorization (PA) or a medical exception for coverage. This often results in a delay in obtaining the prescription. Please expect a **MINIMUM delay of three to five BUSINESS days**. Please be aware that you can still have the pharmacy fill your prescription, but it will not be covered by your insurance. To assist in minimizing PAs, please bring a copy of your insurance co.'s drug list or formulary to your appointment. ***UBHC will not provide prescriptions for pain or stimulant medications***.

_____ 4. ***Treatment Plan:*** Psychiatric medication appointments may be from 15-60 minutes in duration. Counseling appointments may be from 45-60 minutes. Appointment frequency may range from weekly to monthly. At the time your symptoms are stabilized, your care will be transitioned to your primary care provider or a long-term care provider depending on your individual needs or preferences.

_____ 5. ***Right to discontinue treatment:*** UBHC has the right to discontinue treatment for any appropriate reason, such as, excessive cancellations/no shows, or verbal abuse of staff. (Patients should be aware that cursing at staff is grounds for immediate termination.) **When a patient calls to cancel with less than 24 hours-notice this will be considered a no-show. If a patient arrives 10 minutes past the scheduled time this will also be considered a no-show. Copayments for No Shows will NOT be refunded. If a patient has 2 or more no shows in a 6-month period, he/she will be terminated from UBHC services.** In such cases, the patient or patient's representative agrees to accept full responsibility for pursuing alternate behavioral health care. A letter will be sent informing the patient or patient's representative that the treatment is being discontinued and a list of out-patient, inpatient and emergency resources will be provided. All records pertaining to the treatment and diagnosis of patients are the property of the UBHC. Records will be duplicated upon written request with a reasonable charge to the patient. Records will be sent to new provider with a signed consent.

_____ 6. ***Payment for services:*** UBHC has the right to revise fees at any time, for any treatment which has not yet been started. **Payments are due on or before the date of service. Copayments for initial evaluations are due at**

the time of scheduling the appointment. If you are unable to make your payment, another appointment will need to be scheduled – please remember you must be seen to receive a prescription. UBHC will accept Cash, Checks, Debit or Credit Cards for payment. There is a $30.00 fee for all NSF checks.

_____ 7. ***Paperwork Requests:*** Paperwork will only be completed for established patients (i.e. have been under the care of UBHC for a minimum of 3 months). There is a charge for **ALL** paperwork. Paperwork will not be completed until charges are paid in full. The provider has full discretion of any paperwork he/she will or will not complete. Paperwork will take approximately 7 to 10 business days to complete.

_____ 8. ***Risks of treatment:*** The staff at UBHC are available to answer any questions concerning the risks involved with treatment. All medications have certain risks; including possible side effects. These risks include, but are not limited to: allergic reactions, excessive sedation, worsening of mood – symptoms including suicidal thoughts or anxiety.

_____ 9. ***Follow-up appointments:*** I understand that by accepting treatment at UBHC I also consent to future follow-up appointments for the purpose of assessing the outcome of the treatment provided. UBHC staff will attempt to make follow-up appointments but ultimately it is the patient's responsibility to schedule his/her next appointment.

_____ 10. ***Drug screening:*** I understand that by accepting treatment at UBHC I also consent to drug screenings that are completed at the initial visit and randomly at follow-up appointments during the course of my treatment. These medication monitoring screenings will be billed to your insurance.

_____ 11. ***Consent to photograph:*** I understand that photographs will be taken to document and assist with my care. I understand that UBHC will own these images, but that I will be allowed access to view them or to obtain copies of them at a reasonable cost. Images that identify me will be released and/or used outside the organization only upon written authorization from me or the patient representative.

_____ 12. ***Notice of Privacy Practices:*** UBHC may release information to other entities or health care providers, for treatment, payment of services, and for health care operations as described in the "Notice of Privacy Practices". UBHC has prepared this detailed document to help you better understand our policies in regard to the use and disclosure of your personal health information.

_____ 13. ***Consent to treatment:*** By signing below, I am indicating that I have read and I understand the terms of the Consent and Agreement for Treatment. I am either the patient or have the authority to give consent for the patient. I give consent to UBHC to perform necessary or appropriate tasks for proper psychiatric evaluation, diagnosis, and treatment including individual and/or family counseling.

My questions regarding this consent and agreement have been answered.

_____ _____

Patient or Patient Representative Signature — Date

Printed name is acceptable if you don't know how to add a digital signature.

_____ _____

If Patient Representative, Relationship to Patient — Witness

10/7/2020

Email Form

*If the email form button does not work on your system please manually attached the pdf files and email to UBHC@UrgentBehavioralHealthCare.com.