Cedar Ridge Counseling Centers, LLC

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CRNP Medication Management Clients Consent to Services and Policies

This document is specific to clients receiving treatment with a Private Practice CRNP at Cedar Ridge Counseling Centers, LLC (CRCC). This document is designed to inform you, the client, to ensure that you understand our professional relationship including its boundaries and policies. This completed and signed form is REQUIRED to be scheduled.

By signing below, you acknowledge that you have read, agreed to, and signed all Cedar Ridge Counseling Centers, LLC required documents including the "Patient information form, policies for clients form, statement of limited confidentiality form, social media policy form, financial policy form, patients' Rights/Responsibilities form, Notice of Privacy Practices /HIPAA acknowledgment form, and informed consent for Telehealth forms". All these policies and acknowledgments are still enforced in addition to the information and policies outlined below.

QUALIFICATIONS and PRACTICE DISCLOSURE

Your assigned provider is licensed by the Board of Nursing in the state of Maryland as a Certified Registered Nurse Practitioner, specializing in psychiatric/mental health, and/or family medicine, and is ANCC board certified. Although your prescriber is a private practice clinician with Cedar Ridge Counseling Centers, LLC, it may become necessary for another Cedar Ridge prescriber to view your medical records to provide coverage if necessary.

TREATMENT

By signing below, you indicate that you consent to medication management and counseling services. The therapeutic relationship is professional wherein anything you discuss will be held in confidence. The only exceptions are if you disclose information that may directly threaten the well-being or safety of yourself or others or of information indicating possible abuse, which the counselor is obligated to report to appropriate persons or agencies. This applies to both minors and adults. All our communication becomes part of the clinical record and in addition, will abide by all CRCC policies.

You will be a full partner in planning your treatment with your prescriber. This includes the treatment of psychiatric medication management, counseling, and brief therapeutic intervention. If you decide to end counseling services with your prescriber, you have the right to do that at any time. However, medications may be discontinued at any time if any abuse, noncompliance, or misuse is suspected. By signing below, you indicate that you consent to medication management and counseling services and understand and agree that you are obligated to pay in full, any outstanding balance accumulated during treatment and upon termination of the therapeutic relationship (initiated by the client or the counselor). You understand that I must be informed if you are receiving, or plan to receive psychiatric medication management from another provider; I will be happy to coordinate a transition to a new provider should you choose to make a change.

MEDICATION RULES

If medication refills are needed, please email, or call your prescriber directly stating your name, the medication(s), and the dosage when you have 7-10 days remaining. It may take up to 72 business hours for a refill request to be completed; please plan and schedule an appointment before running out of your medication. You further understand if you do not show up or cancel your appointment late and require medications, no changes will be made, and medications will be refilled for a maximum of 7 days until you attend the rescheduled appointment. You understand that if you have not attended an appointment for over 6 months, medication will not be refilled; you will be scheduled for a new intake. If you are discharged or terminated for any reason, a 30-day supply of your medications will be provided. You understand that there are no guarantees of positive outcomes for treatment/therapy; you are responsible for providing accurate information about your history, or your child's history. You authorize the release of any information that is needed to process any insurance claims and help get preauthorization for visits and/or medications. You will be informed of the goals, expectations, procedures, benefits, and possible risks involved in the evaluation and treatment.

TELEHEALTH

Telehealth services utilizing the HIPAA-compliant Zoom platform are available, which allows for a live audio and visual feed. You understand that Telehealth consultation has potential benefits including easier access to care; you also understand that there are potential risks to this technology, including but not limited to disruption of transmission, interruptions and or breaches of confidentiality by unauthorized persons, technical difficulties, and or a limited ability to respond to an emergency. You understand that the decision can be made to discontinue the Telehealth consult/ visit if it is felt that the videoconferencing connections are not adequate for the situation. You understand that if you are experiencing suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth visit services are not appropriate for you. You may require a higher level of care for your immediate crisis. You understand that I may need to contact your emergency contact/ or appropriate authorities in case of emergency. You understand that telehealth visits shall not be recorded by either party unless agreed in writing by mutual consent. Your prescriber accepts most commercial insurances;

however, it is your responsibility to confirm they are in network with your insurance as well as make certain telemedicine for psychiatric medication management is a covered expense before starting your session, otherwise you will be responsible for the total service fee.

EMERGENCY

Your provider operates as a private practice clinician and as a result, has various office hours. You will be given the best way to reach your provider at the time of your first appointment; however, if at any time you are experiencing a psychiatric emergency, a life-threatening emergency, and/or medication adverse effect or other life-threatening concerns go to the nearest Hospital Emergency Room or call 911. The Clinician has up to 48 business hours to acknowledge and return calls and emails.

FEES, CANCELLATION, AND INSURANCE REIMBURSEMENT

The self-pay rate for psychiatric medication management is $200 per initial evaluation and $100 per follow-up. You acknowledge that if you decide to use your insurance coverage you will also be responsible for all copays, coinsurance, and or deductibles required by your insurance company and must be paid in full directly to your provider. Your clinician will review their payment options with you directly. These options may include but are not limited to the following; invoicing before, during, or immediately following your session, cash/check/money order, and automatically charging a credit card on file. The above methods may require your clinician to email and/or text using a HIPAA-compliant and secure payment method. If your insurance company refuses to pay for any reason or retracts a payment previously made, you agree to pay any outstanding balance due. It is your responsibility to confirm your provider is in your network and covers your required service. Please see CRCC's confidentiality policy for communication that is required with your insurance company.

If you are unable to keep an appointment, you must notify your provider at least 24 hours in advance. If I do not receive such advance notice, you will be responsible for paying $100.00 for the session that you missed. There will be no charge for canceling appointments when at least 24 hours' notice is given. There will be no charge for telephone contact initiated by the client involving treatment issues when the duration of the contact is less than 10 minutes. Email contact may be initiated by the client, but a follow-up appointment may be required if medication changes, or counseling may be needed. Telephone contact exceeding 10 minutes will be treated as a 'session' and billed to your insurance company or as a self-pay follow-up appointment if your insurance does not cover telemedicine services.

DOCUMENT REQUESTS

Document requests can be uploaded through the Cedar Ridge Counseling Centers, LLC. portal and an email sent to your prescriber explaining the need. The provider needs a week minimum for all document requests. This includes school forms, FMLA, etc. Each provider works independently and will determine if the request can be honored, there is no guarantee that FMLA and/or disability paperwork will be completed.

Additional fees will be charged that may or may not be covered by the insurance company: Professional forms/Letters: employment forms, disability, retirement, legal action, etc. Forms may take up to 7 business days from the time of the request to complete. Fees are pro-rated at the hourly rate of $150. If subpoenaed for court the fee is $300 per hour, plus additional fees, if applicable.

TERMINATION OF SERVICES

Any client's services may be terminated for missing two appointments (no-show or less than 24-hour cancellation). Services may also be terminated if the client is dishonest to the point of violating trust and/or the established therapeutic relationship, abuses or misuses medication prescribed, or routinely does not comply with recommended treatment. You may be immediately discharged if your behavior is a threat to your provider, exhibits emotional intimidation, or verbal abuse of any kind; sending abusive messages or phone correspondence/email correspondence. If treatment is terminated, a notice of termination letter will be sent to the address of file, and I will send in for a thirty-day supply of medications to the pharmacy on file unless refills have already been on file for said medication and/or the medication was not taken as prescribed (non-compliance, misuse, or abuse). Services may also be terminated if a balance goes unpaid after being attempted to collect for three weeks.

CONSENT TO TREAT

By signing below, you indicate that you consent to medication management and counseling services and understand and agree that you are obligated to pay in full, any outstanding balance accumulated during treatment and upon termination of the therapeutic relationship (initiated by the client or the counselor). In addition, if you do not pay for your sessions within two weeks, treatment will be suspended until payment has been made or a payback schedule has been mutually agreed upon. All balances must be paid, in full, at the end of each calendar year. By signing below, you indicate that you have read this contract in full, and both understand and agree to its contents. You may revoke this consent in writing except to the extent that action has been taken to rely on this consent before being revoked.

Current Medications: _____

_____

Signed by (print): _____ **Relationship to client:** _____

Signature: _____ **Date Signed:** _____

Cedar Ridge Counseling Centers Patient Information

☐ **New Patient** ☐ **Updated Information** ☐ **Adult** ☐ **Child**

Therapist:_____ **Date:**_____

Patient's Name: _____ D.O.B. _____

Address: _____

City, ST, Zip_____

PH: (H) _____ (W) _____ (C) *_____

Employer: _____ Soc Sec #_____

Marital Status: _____How Long: _____ email: **_____ M_____ F_____

Complete ONLY if patient is a child:

School: _____

Mother's Name: _____ Work # _____

Employer: _____ How Long: _____

Father's Name: _____ Work # _____

Employer: _____How Long: _____

Patient's Primary Ins. Co. _____Phone #_____

Patient's Membership #: _____Group #: _____

Policy Holder Information for primary insurance:

Name: _____ DOB_____ Soc. Sec #_____

Insured's Employer: _____Relationship: _____

Secondary Ins. (if applicable) _____Phone #_____

Patient's Membership #: _____ Group #: _____

Policy Holder Information for secondary insurance:

Name: _____ DOB_____ Soc. Sec #_____

Insured's Employer: _____Relationship: _____

If we are unable to contact you, please list the closest relative or friend:

Name: _____

Relationship: _____ Phone #_____

I authorize the release of any medical information necessary to process this claim, payment of medical benefits to the physician or supplier of services and the release of medical information to my primary care Physician

☐ ***YES, I give CRCC permission to use my CELL number listed above to send appointment reminders**
****Please use email address above for appointment reminders**

Client Signature_____**Date**: _____

If Minor, Guardian Signature_____ **Date:** _____

Primary Care Physician: _____ Phone # _____

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COUNSELING CENTERS, LLC

PATIENT POLICIES

Please read the information below and feel free to ask any questions. You have the right to ask for as much information as you would like to make an intelligent decision about the services you desire. Hard copies of each of policy below are available at request, and/or can be reviewed at any time through your patient portal.

1. **APPOINTMENTS:** Standard appointment time is 45 to 60 minutes for a psychotherapy session and if you would like more time, please discuss this with your therapist. If you are late for the session, that time will be lost from the session. Your therapist will make every effort to be available at the scheduled time.
2. **FAILED APPOINTMENTS:** The time that has been reserved for you is your time. Appointments not cancelled 24 hours in advance will be subject to a cancellation fee. You, not your insurance company, will be billed a fee of $85 for appointments missed with a LCSW, LCPC, LGPC, or LMSW and $100 for appointments missed with a CRNP, Ph.D. or Psy.D. This policy applies to scheduled intakes and all first-time appointments. Lack of payment may result in the inability to reschedule a new appointment.
3. **BILLING:** Clients are responsible for obtaining accurate information from insurance carriers as to deductibles, co-payments, and pre-certification. Any errors in information received, resulting in a balance owed to provider, will be the responsibility of the client to pay. Clients are also responsible for becoming aware of any changes in their coverage and notifying their therapist. Co-payments are due when services are rendered. Clients are ultimately responsible for fee payment, regardless of coverage. Your signature below authorizes your insurance company to pay Cedar Ridge directly for their share of the fees.
4. **TELEPHONE:** Telephone contacts between sessions should be limited to critical issues or appointment scheduling. If possible, telephone contacts should be limited to normal business hours (Monday – Friday, 8:30a.m. – 5:00p.m.). **Extended phone contact will result in a billed session.**
5. **MISCELLANEOUS FEES: Returned checks** will result in a service charge of $35.00. A fee will be assessed at the usual hourly rate for letters, reports, forms, etc. requested by client.

Please initial each statement and then sign below. I, undersign that I

_____ agree to policies described above.
_____ have reviewed and agree with **the Statement of Limits of Confidentiality**
_____ have read and agree with the **Patients' Rights and Responsibilities**
_____ have read and agree with the **Social Media Policy**
_____ have read and agree with the **Financial Policy.**
_____ have read/received a copy, if requested, of this Office's **Notice of Privacy Practices**.
_____ have read and agree with the **Consent for Telehealth Services**
_____ have read and agree with the **COVID-19 Contract.**
_____ give consent for evaluation, psychotherapy, and /or psychological testing.

_____ _____

Patient or Authorized Signature: **Date:**

_____ _____

Print Patient Name **Print Signature Name if other than Patient**

CEDAR RIDGE COUNSELING CENTERS, LLC

Statement of Limits of Confidentiality

The law protects the privacy of all communications between a patient and psychotherapist. In most situations, information about your treatment can only be released to others if you sign a written authorization form that meets certain legal requirements imposed by Health Insurance Portability Accountability Act (HIPAA) and/or Maryland law. However, in the following situations, no authorization is required:

- For administrative purposes, such as scheduling and billing, basic information may be communicated to other office staff, who are also bound by rules of confidentiality.
- Discloses may be required by health insurers to collect overdue fees.
- If you are involved in a court proceeding and request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege law. Information cannot be provided without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court order is likely.
- Information may be required by a government agency for health oversight activities.
- If a client files a complaint or lawsuit, relevant information regarding the client may be provided in the provider's defense.
- When consultation with other health and mental health professionals about a case is needed, every effort is made to conceal your identity.

There are some situations in which therapists are legally obligated to take actions to protect others from harm, which may necessitate revealing some treatment information:

- If there is reason to believe that a child or vulnerable adult has been subjected to abuse or neglect, or that a vulnerable adult has been subjected to self-neglect, or exploitation, the law requires that a report be filed with the appropriate government agency, usually the local office of the Department of Social Services. Once such a report is filed, additional information may be required.
- If a patient has a propensity for violence and the patient indicates that he/she has the intention to inflict imminent physical injury upon a specified victim(s), protective actions may be required. These actions may include established and undertaking a treatment plan that is calculated to eliminate the possibility that the patient will carry out the threat, seeking hospitalization of the patient and/or informing the potential victim or the police about the threat.
- If there is an imminent risk that a patient will inflict serious physical harm or death on himself/herself, or that immediate disclosure is required to provide for the patient's emergency health care needs, appropriate protective actions may be indicated, including initiating hospitalization and/or notifying family members or others who can protect the patient.

If such a situation arises, every effort will be made to fully discuss it with the client before taking any action and disclosure will be limited to what is necessary.

Definition of Child Abuse and Neglect:
Child Abuse: Any physical or mental injury of a child by any parent or other person who has permanent or temporary care or custody or responsibility for supervision of a child, or by any household or family member under circumstances that indicate that the child's health or welfare is harmed or at substantial risk of being harmed; or sexual abuse of a child, whether physical injuries are sustained or not.
Neglect: The leaving of a child unattended or other failure to give proper care and attention to a child by any parent or other person who has permanent or temporary care or custody or responsibility for supervision of the child under circumstances that indicate that the child's welfare is harmed or placed at substantial risk of harm, or mental injury to the child, or a substantial risk of mental injury

Definition of Vulnerable Adult, Abuse, Exploitation, and Neglect of a Vulnerable Adult:
Vulnerable Adult: A vulnerable adult is an adult who lacks the physical or mental capacity to provide for his/her daily needs.
Abuse: The sustaining of any physical injury by a vulnerable adult as a result of cruel or inhumane treatment or as a result of a malicious act by any person.
Exploitation: Any action which involves the misuse of a vulnerable adult's funds, property, or person.
Neglect: The willful deprivation of a vulnerable adult of adequate food, clothing, essential medical treatment, or habilitative therapy, shelter, or supervision.

Reporting Procedure:
Therapists are legally mandated to report cases of child abuse and neglect, and abuse of vulnerable adults, to the Department of Social Services (DSS). Initially a telephone call is made as soon as possible and followed by a written report within 48 hours after the contact. In the case of child abuse, a copy of the report is sent to the District Attorney's office. In the case of adults abused as children, the therapist will encourage the client to make the report to DSS, but if that does not occur, the therapist will make the report after discussing the process with the client. The purpose is to protect children who may be currently at risk of abuse by the abusing person.

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Patients' Rights and Responsibilities

- Clients have the right to be treated with dignity and respect.
- Clients have the right to fair treatment regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Clients have the right to have their treatment and other information kept private.
- Only in an emergency, or if required by law, can records be released without client permission.
- Clients have the right to information from staff/providers in a language they can understand.
- Clients have the right to information about providers and to list certain preference in a provider.
- Clients have the right to know the clinical guidelines used in providing their care.
- Clients have the right to know about State and Federal laws that relate to their rights and responsibilities.
- Clients have the right to easily access timely care in a timely fashion and know about their treatment choices regardless of cost or coverage by the benefit plan.
- Clients have the right to share in developing their plan of care, to know of their rights and responsibilities in the treatment process, to receive services that will not jeopardize their employment and to freely file a complaint or appear and learn how to do so.
- Clients have the right to ask give input on the Members' Rights and Responsibilities policy, know about advocacy and community groups and prevention services.
- Clients have the responsibility to give providers information they need in order to deliver the best possible care.
- Clients have the responsibility to inform their provider when the treatment plan no longer works for them.
- Clients have the responsibility to follow their medication plan. They must tell their provider about medication changes, including medications given to them by other providers.
- Clients have the responsibility to treat those giving them care with dignity and respect.
- Clients should not take actions that could harm the lives of Cedar Ridge Counseling Centers, LLC employees, providers, or other members.
- Clients have the responsibly to keep their appointments. Clients should call their providers as soon as possible if they need to cancel visits.
- Clients have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.
- Clients have the responsibility to let their provider know about problems with paying fees.
- Clients have the responsibility to let their provider know about problems paying fees.
- Clients have the responsibility to follow the plans and instructions for their care. The care is to be agreed upon by the member and provider.
- Clients have the responsibility to keep current with their fees.
- Clients have the responsibility to report abuse and fraud.
- Clients have the responsibility to openly report concerns about the quality of care they receive.

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Social Media Policy

The following is a document which outlines our office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet.

If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

- I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise patient confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet, and we can talk more about it
- If I keep a Facebook Page for my professional practice to allow people to share my blog posts and practice updates with other Facebook users. You are welcome to view my Facebook Page and read or share articles posted there, but I do not accept clients as Fans of this Page. I believe having clients as Facebook Fans creates a greater likelihood of compromised client confidentiality and I feel it is best to be explicit to all who may view my list of Fans to know that they will not find client names on that list.
- If you should choose to follow me on social media of any sort, please note that I will not follow you back. I only follow other health professionals on social media, and I do not follow current or former clients on blogs or social media. My reasoning is that I believe casual viewing of clients' online content outside of the therapy hour can create confusion regarding whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.
- Please do not use messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure, and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by phone or email.
- You may find my Cedar Ridge Counseling Centers, LLC on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client. Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me regarding your feelings about our work together, there is a good possibility that I may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. *None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client, and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you, in any forum of your choosing.

Thank you for taking the time to read and review our social media policy. If you have any questions or concerns,

please do not hesitate to talk openly with your therapist about them.

Financial Policy

This Financial Policy of Cedar Ridge Counseling, LLC ("the Provider") is designed to outline patient and practice responsibilities to avoid any misunderstandings or disagreements concerning payment for professional services. Patients are encouraged to read the following carefully and present any questions that they may have about these terms and conditions with your provider before beginning treatment.

Patients without insurance coverage or insurance benefits to cover services rendered:
Patients who do not have any insurance coverage are expected to pay for services at the time of the visit. Payment plans may be available for patients upon request and are at the discretion of each individual provider.

Patients who are covered by Insurance, HMO or Managed Care Plan where CRCC is in network:
Our office participates with numerous insurance companies. The patient is responsible to provide us with valid health insurance information and execute the assignment of benefits forms so that the Provider may bill the insurer for services rendered. The patient is required to notify us in the event of any insurance changes.

If you have an insurance that our practice participates with:

- The patient is responsible to pay any co-payment or estimated balance at the time of the visit.
- Any services not covered by insurance are the patient's responsibility and payment in full is due at time of visit.
- The patient is solely responsible for ensuring that he or she is covered by the insurer for services rendered by the Provider. Specific coverage issues should be addressed to the insurance company's member services department. It is recommended that you contact your insurer prior to receiving services to verify and confirm that insurance coverage is available for the specific treatment and clinician as it relates to the diagnosis.
- The patient is responsible to make sure that any required referrals are provided to the practice at the time of the visit. The patient will be financially responsible for any charges resulting from the lack of a referral.
- In the event that your insurer fails to remit payment within 60 days, it is the patient's responsibility to pay the balance in full. We will bill for the payment due if 60 days from the date of treatment have expired and payment from the insurer has not yet been received by the Provider. The Provider will reimburse you if payment is received from your insurer.

If patient has an insurance that our office does not participate with:
Payment is expected at time of service. It will be treated as an out of network session and billed to the patient as a self-pay,

Other:
As previously stated, and agreed upon in our ***Policies for Clients.***

- Patient is responsible for all fees incurred by the Provider as a result of a bounced check or any other instrument dishonored by the patient's bank for any reason. Payment will be due before the next scheduled visit.
- The patient is responsible to give the Provider a minimum of 24 hours' notice if a scheduled appointment is to be cancelled. In the event the patient fails to provide such notice, and fails to appear for the scheduled appointment, the patient will be responsible to pay a no-show fee. If patient fails to show to a scheduled appointment for two visits, your provider retains the rights to discontinue that scheduled time, to offer to other patients.
- In the event that the patient's insurer does not cover services provided due to a noncovered diagnosis or if services are deemed not medically necessary, or for any reason, it is the patient's responsibility to pay for services in full.

I understand if I have an unpaid balance to Cedar Ridge Counseling Centers Private Practice Clinician and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.

In order for Cedar Ridge Counseling Centers Private Practice Clinician or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Cedar Ridge Counseling Centers Private Practice Clinician and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

My signature on the Patient Polices confirms that I have read this Financial Policy and understand my role and responsibilities and hereby authorize the treating provider with Cedar Ridge Counseling, LLC to bill the patient or responsible party for any charges as outlined above.

CEDAR RIDGE COUNSELING CENTERS, LLC

Notice of Privacy Practices (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 15, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of the Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use ore disclose your health information to a physician or other healthcare providers providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Options: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provide performance, conducting training programs, accreditation, and certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those descried in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, the prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacitation or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x- rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorizations.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Marketing Health-Related Services: We will not use your health information for marketing communications without your authorization.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail message, postcards, or letters)

Patient Rights Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of the Notice. If you request copies there may be a nominal charge for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of the Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost- based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or be electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with the decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer:	Michael A Fry, ESQ
Telephone:	(410) 552-0773
Address:	Cedar Ridge Counseling Centers, LLC PO Box 1229, Sykesville, MD, 21784

CEDAR RIDGE
COUNSELING CENTERS, LLC

Informed Consent for Telehealth Services

Definition of Telehealth: Telehealth involves the use of electronic communications to enable clinicians to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the following rights with respect to telehealth:

1. I understand that the form I signed regarding the confidentiality of my personal information, under HIPAA, also applies to telehealth. (A copy of our policies and privacy information can be furnished upon request)
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Your provider utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth via ZOOM.
4. Your clinician follows the State of Maryland COMAR Regulations for telehealth: 10.32.05 as well as their respective board regulations and ethics. Your clinician has also received training to provide telehealth services.
5. At any time, emergency or crisis situations may arise and audio/video-based psychotherapy may not be the most appropriate modality for therapy. If you are in crisis or in an emergency situation, you should immediately call 911 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services:

Cedar Ridge Counseling will bill insurance for telehealth services when these services have been verified by an individual's insurance plan. The standard copay and/or deductibles would apply as does the terms of our financial policy (attached with this document). Please note that you may have a deductible that still needs to be met or copay due at the time of service.

By signing the Patient Policies above, you authorize your clinician to charge your credit card (if you choose to pay by credit) for payments.

Patient Consent to the Use of Telehealth:

I have read and understand the information provided above regarding telehealth, have discussed it with my clinician, and all questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services.

I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. My signature on the Patient Policies form indicates that I have read and agree to the terms of this document.

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign the Patient Policies form above, it will be an official agreement between us.

Decision to Meet Face-to-Face
We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Your signature on the patient policies acknowledges that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free.
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I will not charge you our normal cancellation fee.
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you will not move chairs or sit where we have signs asking you not to sit.
- You will wear a mask in all areas of the office (I [and my staff] will too).
- You will keep a distance of 6 feet and there will be no physical contact (e.g., no shaking hands) with me [or staff].
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- If you are bringing your child, you will make sure that your child follows these sanitation and distancing protocols.
- You will take steps between appointments to minimize your exposure to COVID.
- If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know.
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know.
- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth.

I may change the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or my staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing the Patient Policy form above you agree that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature on the Patient Policies is acknowledgement that you agree to these terms and conditions.