WELL BEING SYSTEMS, PLLC
HEALTHCARE PROVIDER – PATIENT SERVICES AGREEMENT

Name_____Date of Birth_____

Welcome, I am pleased you have chosen us as your healthcare provider. Please read the following document carefully as it contains important information about our professional services and practice policies.

MEDICATION SERVICES

Your treatment may include taking medication. There are wide varieties of medications available for sleep or sleepiness problems as well as for mental health problems such as depression or other mood disorders like bipolar disorder, anxiety, posttraumatic stress disorder, psychotic disorders and others. Prescribing of medication must take into account your personal medical history, other medications that you take, allergies to medicines or other products and your treatment goals. When I recommend a medication prescription for you, I will inform you of significant benefits and risks, answer any of your questions to the best of my ability and advise you about appropriate regular monitoring of your use of medication, including any necessary periodic laboratory tests.

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CONTACTING ME

Due to my work schedule, I am not immediately available by telephone. Telephones are answered by office staff or our answering service. Every effort will be made to return your call promptly, either by your provider or the office staff, during business hours. After hours emergencies will be returned by the on-call provider. If you are unable to reach us during normal business hours, and feel you cannot wait for a return call, contact 911 or go to the nearest emergency room.

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LEGAL LIMITS ON CONFIDENTIALITY PROTECTIONS

The law protects the privacy of all communications between a patient and a healthcare provider. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by the Health Information Portability and Accountability Act (HIPAA). There are other situations that require only written, advance consent. However, there are some situations in which I am permitted or required to disclose information without either your consent or Authorization. These situations are primarily related to danger to yourself or to others and child or elder abuse or neglect. If such situations arise, I will make every effort to discuss them with you before taking any action and I will limit my disclosure to what is necessary. For details on the limits of your confidentiality required by law, please refer to my office form entitled, “Notice of Healthcare Providers Polices and Practices to Protect the Privacy of your Health Information,”

especially Section II ("Uses and Disclosures Requiring Authorization") and Section III ("Uses and Disclosures with Neither Consent nor Authorization"). Your signature on this Agreement provides consent for those activities. While this written summary of exceptions of confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex and I do not give legal advice. In situations where specific advice is required, formal legal advice may be needed.

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MINORS & PARENTS

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Because privacy in therapy is often crucial to successful progress, it is sometimes my policy to request an agreement from parents that they consent to give up or suspend their access to their child's records. If they agree, during treatment I will provide them only with general information about the progress of the child's treatment, unless the child agrees otherwise. Before giving parents any information that the child expects to be confidential, I will discuss the matter with the child, if possible, and do my best to handle any objections. Important exceptions to this confidentiality procedure involve any issue or potential issues regarding matters of the child's safety. I will ensure that parents are rapidly informed about any safety concerns that come to my attention. This may be done by promptly scheduling a joint session to be attended by both child and parents so that the child can inform the parents of the safety issue himself or herself in the context of the support offered in a therapy session. Alternatively, if the child is not able to agree to a joint meeting for any reason or if the safety concern is urgent, I may telephone one or both parents to quickly discuss the relevant safety concern. Parents should feel free to clarify this policy or request modification to it at any time they become aware of a safety concern for their child.

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PROFESSIONAL RECORDS

You should be aware that, pursuant to the Health Information Portability and Accountability Act (HIPAA), I keep Protected Health Information (PHI) about you in two sets of professional records. Please refer to the "Notice of Healthcare Provider's Policies and Practices to Protect the Privacy of Your Health Information," for more information regarding the above.

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PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of Protect Health Information (PHI). These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI disclosures are sent;

having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form and my privacy policies and procedures. I am happy to discuss any of these rights with you.

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CONSENT FOR TREATMENT AND CONSULTATION

I authorize and request that Well Being System's Providers, carry out behavioral health treatments, and/or diagnostic procedures that now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I also understand that while the course of treatment is designed to be helpful, it may at times be difficult and uncomfortable.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE MAY RECEIVE ADDITIONAL HIPAA INFORMATION DESCRIBED ABOVE, UPON REQUEST.

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Patient (Authorized Parent/Guardian) Print Name

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Patient (Authorized Parent/Guardian) Signature **Date**