Arbor Vitae Behavioral Health
A place that inspires both healing and growth

1258 Purdytown Turnpike
Lakeville, PA 18438
(570) 647-9277
kelly.lawrence@arborvitaebh.org

Agency Treatment Consent Agreement

Arbor Vitae Behavioral Health, LLC is committed to providing quality, professional healthcare to all of our clients. The treatment information is handled with the utmost care to ensure privacy. This document is for consent and agreement for clinical treatment, integrative healthcare, and to understand client rights and the Agency's rights.

I, _____, hereby attest that I have voluntarily entered
(Client's First and Last Name)
into treatment and give my consent for myself at Arbor Vitae Behavioral Health, LLC, hereby referred to as the "Agency". Further, I consent and agree to have treatment provided by the Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC), who I acknowledge, understand, and agree, is an independent contractor of Arbor Vitae Behavioral Health, LLC, and acts pursuant to his or her own professional license and professional judgment, which is not subject to the judgment or control of Arbor Vitae Behavioral Health, LLC.

Any person providing services is a third-party beneficiary to this agreement and may enforce any rights hereunder. The rights, risks and benefits associated with the treatment have been explained to me. I understand I will be given **Addendum PMHNP-BC**, and I will have the opportunity to ask any questions regarding the informed consent and will have all of my questions, if any, addressed. I also hereby understand, agree, and warrant, that I will meet and discuss the treatment and risks of treatment with the Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC), and provide written consent for the healthcare prior to the start of my treatment. I understand that treatment may be discontinued at any time by either party when not prohibited by applicable professional standards. The Agency encourages that this decision be discussed with the Psychiatric Mental Health Nurse Practitioner (PMHNP-BC). This will help facilitate a more appropriate plan for discharge.

Non-Voluntary Discharge from Treatment: I acknowledge I may be terminated from the Agency non-voluntarily if:

A) I exhibit any physical violence, verbal abuse, carry weapons, or engage in illegal acts at the Agency and/or,

B) I refuse to comply with stipulated program rules, refuse to comply with treatment recommendations, do not provide the appropriate forms upon initial treatment, or do not make payment or payment arrangements in a timely manner and/or,

C) I do not attend my scheduled appointment for two (2) consecutive sessions without notifying the Agency twenty-four (24) hours prior to the scheduled appointment indicating I am able to attend the appointment.

I acknowledge I will be notified of the non-voluntary discharge immediately.

Client Notice of Confidentiality: The client record ("designated record set") and all subsequent or additional protected health information maintained by the Agency is protected by

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Federal and/or State laws and regulations. Generally, the Agency may not disclose to a person outside the Agency that I attended treatment or disclose any information identifying myself as an alcohol or drug abuser unless:

A) I consent in writing and/or,
B) The disclosure is allowed by a court order and/or,
C) The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, program evaluation, or for the purposes for supervision with the collaborative physician. The disclosure is otherwise permitted or required pursuant to HIPAA and our policies and procedures.

Federal and/or State laws and regulations concerning confidentiality do not generally protect or restrict information about a crime committed by a person, including a client, either at the Agency, against any person who works for the program, or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child, vulnerable adult abuse, or neglect from being reported under Federal and/or State laws to appropriate State or Local authorities. In addition, there are laws and standards, which can require such disclosures under certain circumstances.

Clinicians and other health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Agency's duty to warn any potential victim, when a significant threat of harm has been made. In the event of my death, my spouse or my child(ren)'s parent or legal guardian may have a right to access my records.

Professional misconduct by a clinician must be reported by other clinicians, in which case related client records may be released to substantiate disciplinary concerns. Legal custodial parents or legal guardians of non-emancipated minor clients may have the right to access my records.

Third-Party Payer Rights: In order for the Agency to contact the applicable insurance company on behalf of my clinician, this consent must be signed by me to enable the Agency pre-authorization to request eligibility and benefit information, to file any insurance claim or process necessary paperwork. Client data of clinical outcomes may be used for program evaluation or with your insurance company, but Protected Health Information (PHI) as stipulated by the Department of Health and Human Services will not be disclosed to any outside sources without an **Authorization To Release Information** form, except as permitted or required.
I hereby consent to the disclosure of client records to any listed third-party payer for the purpose of receiving payment reimbursement. This includes a health insurance company and Employee Assistance Program (EAP) providers. The Agency is not responsible for any client disclosure (i.e. diagnostic information, date of service, billing information, etc.) from a health insurance company to the primary insured.

Disclaimers and Limitations of Liability: I understand, agree, and conclusively stipulate that Agency does not direct or control the services provided by its independent contractors, has no duty to direct, control, supervise, or train its independent contractors, and Agency is not responsible for the acts or omissions of its independent contractors. All independent contractors are properly licensed and insured, and are employees of their own independent legal entities. It is expressly understood and agreed that the Agency's liability is limited to the fees paid for services and in no event will the Agency be liable for any special, incidental, consequential, or indirect damages. It is intended this limitation apply to any and all

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liability or cause of action however alleged or arising, unless otherwise prohibited by law, including but not limited to negligence, breach of contract, or any other claim whatsoever.

Missed Appointments and Cancellations: I understand if I am unable to keep a scheduled appointment with my health care provider, I understand a twenty-four (24) hour advance notification is required by either calling my health care provider directly or the business office at (570)647-9277 x2600. If this notice is not given, the **FULL SESSION FEE** will be charged for late cancellations or missed appointments.

Payment Due at Time of Service: I hereby acknowledge that all fees are due at the time of service and are to be made payable to: Arbor Vitae Behavioral Health, LLC. Payment can be made by either by: check, cash, authorized credit/debit card, or HSA insurance card. The Agency is not responsible for any HSA insurance card that doesn't approve my clinical treatment. As such, any declined HSA insurance card is my responsibility and I must provide another form of payment at the time of service. Any nonsufficient funds (NSF) received via a check or bank/debit card will result in a fee of Thirty-Dollars ($30.00). When appointment fees are not paid in a timely manner, I understand a collection agency may be given appropriate billing and financial information about me, but will not receive any clinical information. If my insurance company doesn't provide financial reimbursement for my treatment or is cancelled at any time during treatment, I am responsible for any of the outstanding balance.

My signature below indicates that I understand the rights of this Agency and acknowledge I have read and understand the Notice of Privacy Practices form. I hereby consent to treatment and agree to abide by the above stated policies and agreements with the Agency.

_____	_____
Signature of Client or Legal Representative	**Printed Name of Client or Legal Representative**
_____	_____
Printed Name of Person under Legal Guardianship	**Date**

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PMHNP-BC Informed Consent Agreement

Arbor Vitae Behavioral Health, LLC. is committed to providing quality, professional healthcare to all of our clients (client is referred to as "I", "me" or "my" herein). This document involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. This addendum modifies the agreement and Consent between Client and Arbor Vitae Behavioral Health, LLC., who acknowledge and agree that this Addendum is incorporated into and made a part of the agreement and Consent initially signed by Client, the terms and provisions of which, except as expressly modified in this Addendum, are hereby affirmed and ratified.

It is expected that you are under the care of a primary care physician or medical specialist and pregnant clients are also being managed by an appropriate healthcare professional, and clients seeking adjunctive cancer support are also under the care of an oncologist. I understand that treatment may be discontinued at any time by either party when not prohibited by applicable professional standards. The Agency encourages this decision be discussed with the Psychiatric Mental Health Nurse Practitioner (PMHNP-BC) and myself. This will help facilitate a more appropriate plan for discharge.

I hereby request and consent to the performance of healthcare services (or on behalf of the client named, for whom I am legally responsible) by the Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC) providing services to me now and in the future.

I request and authorize the Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC) to provide and perform an assessment, diagnose, care, and evaluate my emotional and physical health, which also may include ordering medical diagnostic tests and/or procedures, services, and education that are considered advisable for my health and well-being. Following an initial assessment, a treatment plan is developed jointly by the Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC) and me. The frequency and duration of treatment varies and will depend on my individual needs.

I understand, agree, and acknowledge that I am entitled to the following information prior to making an informed decision regarding medication administration:

- My condition or diagnosis.
- Targeting symptoms of the condition and reasons for medication(s).
- Alternative treatments with benefits and potential risks involved.
- Medication name, dosage, frequency, and route of administration, and expected duration of use.
- Psychotropic medication therapy may include lab and/or diagnostic tests on a regular required basis and monitoring potential effects.
- I will inform the Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC) of all my known allergies.

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- I will inform the Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC) of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, and any other recreational drug or alcohol use.
- I should avoid drinking alcoholic beverages when consuming psychotropic medication(s).
- I understand it is my responsibility to read or will be read to all of the drug labeling information as to all of my medications, including prescriptions, over-the-counter remedies, herbal therapies and supplements, and any other medication or drug, and I understand it is my responsibility, also to ask questions of my pharmacist regarding any questions or concerns I have regarding any or all of my medications.
- I am aware and accept that no guarantees about the results of the treatment have been made.
- I acknowledge I will be advised of the probable consequences of declining recommended or alternative therapies. The Psychiatric Mental Health Nurse Practitioner Board-Certified (PMHNP-BC) will answer, and will continue to answer, any or all of my questions regarding the treatment plan.
- Common medication side effects may occur, as well as rare potentially life-threatening side effects, and fetal risk during pregnancy.
- I understand and accept the possible side effects of any prescribed psychotropic medication or drug; and I have and will continue to, also ask questions of my pharmacist regarding any questions or concerns I have.
- I acknowledge, agree and understand immediate discontinuing of certain medications can risk additional side effects; and therefore, some medications should be discontinued gradually under the guidance of the Psychiatric Mental Nurse Practitioner –Board Certified (PMHNP-BC).

I understand it is the responsibility of the Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC) to explain to me the nature of any diagnostic, therapeutic, medical and/or psychiatric-mental health treatment plan necessary to treat me and to explain risks and consequences associated with the services.

The Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC) does not prescribe or dispense addiction treatment medications such as, but not limited to: Naloxone and Methadone, but may refer a client to a treatment center/provider as needed. I understand the Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC) does not prescribe opioid pain medications and there are no controlled substances stored on Arbor Vitae Behavioral Health, LLC premises.

I understand that if I encounter a personal emergency that requires prompt attention, I may contact the Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC) through the HIPAA compliant office number at 570-647-9277 x2600. (Please allow at least twenty-four (24) hours for a follow up phone call.)

If an emergency arises that requires prompt attention and you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room. The National Mental Health Crisis Line is 988.

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I understand the Clinical Director, Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC), Collaborative Physician, and administrative staff may review my client record and any lab and diagnostic reports, but all my records will be kept confidential and will not be released outside of the Agency without my written consent.

I understand that I have voluntarily chosen to seek treatment, am of legal age and authorized to execute this addendum. I will immediately alert the Psychiatric Mental Health Nurse Practitioner (PMHNP-BC) of any medical conditions which may adversely affect my personal health or effectiveness of the medication, including new prescriptions from other providers or over the counter medications, including herbal supplements.

I understand that if I experience any side effects, I am responsible for following up with my Psychiatric Mental Health Nurse Practitioner (PMHNP-BC) prescriber at my expense. I understand that receipt of this medication is subject to reporting, by my Psychiatric Mental Health Nurse Practitioner (PMHNP-BC) to my primary care physician and/or the manufacturer, if required, and I will authorize these disclosures. Medical recommendations may be made to my Primary Care Physician that relate to physical symptoms and diagnostic findings that may be related to my mental health state.

I understand that my Psychiatric Mental Health Nurse Practitioner (PMHNP-BC) may access pharmaceutical databases to review my current and past medications for my well-being and safety.

I understand that there are treatment options available for my condition other than Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNP-BC) recommended procedures. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

Consent:

I confirm that I have read, or have been read to me, the above consent. I understand recommended treatment may include medication therapy, including psychotropic medications, and these medications will be explained to me generally to my satisfaction. I will have the opportunity to ask questions and I can continue to ask questions to ensure I'm fully informed regarding each and all medications, including their interaction, or potential interaction. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I consent to treatment and agree to abide by the above stated policies and agreements with the Agency. Even after signing, I understand I can still refuse any medication or withdraw my agreement completely at any time.

_____ _____

Signature of Client or Legal Representative Printed **Name of Client or Legal Representative**

_____ _____

Printed Name of Person under Legal Guardianship **Date**

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Credit Card Authorization Agreement

I, _____, am the holder of

Visa____, MasterCard_____, AMEX _____, Discover_____ (check one please)

Cardholder name: _____

Card number: _____

Expiration date: __mm_____ /___yr_____ CVV# (on back of card): _____

Card Holder's Zip Code: _____

I authorize Arbor Vitae Behavioral Health to charge my credit card. Initial_____

I understand and agree that the Arbor Vitae Behavioral Health will charge my credit card $100.00 fee if I do not cancel any appointment within 1 business day, if I am late for my scheduled session or if I do not show for my scheduled session. Initial_____

I understand and agree that the Arbor Vitae Behavioral Health will charge my credit card for any outstanding balance past 30 days from date on my invoice. Initial_____

I understand that if the above card information is incorrect or is denied I will be charged a $50 fee due immediately. Initial _____

I understand my insurance will not pay for late cancellations, missed appointments, or fees and I will be responsible for payment. Initial _____

I understand that if I refuse to leave a valid card on file, I must pay all balances within 30 days or I will be discharged from Arbor Vitae Behavioral Health and I will no longer receive treatment including: medication management and/or psychotherapy. I also understand that all no-show fees are due before I can schedule a new appointment and any current appointments will be cancelled until the fee is paid. Initial_____

I hereby authorize the Arbor Vitae Behavioral Health to process my credit card with their merchant services. I understand that the Arbor Vitae Behavioral Health is not responsible for any security or liability issues with merchant services. Initial_____

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I have read this entire agreement and understand that I will be held fully responsible for its terms and charges and I agree that all charges are final and that there are no refunds for services rendered.

Patient Name (Print)_____

Patient/Parent/Legal Guardian Signature_____ Date: _____

Witness Signature: _____ Date:_____