# *Mind Flex LLC*

## *Patient's/Client's Informed Consent for Psychological, Evaluation, Consultation, Treatment and/or Biofeedback Training*

I understand that I am undergoing a formal consultation with Dr. Lee A. Picariello to determine if intervention is necessary or advisable. I hereby authorize and consent to the administration of all diagnostic procedures and/or any assessment measures that are part of this evaluation. I understand that after review of this evaluation and possible testing results, therapeutic treatments may be recommended or considered necessary in the judgement of the psychologist, including counseling, consulting, psychotherapy, peak-performance-training, traditional biofeedback, i.e. heart rate variability, (HRV). I understand that I have the right to be informed of the various steps and activities involved in receiving these services. I understand that I have the right to make an informed decision whether to accept or refuse suggestions. I understand that I may revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent.

I understand that I have the right to humane care and protection from harm, abuse, or neglect. I also understand that state and local laws require that my psychologist report all cases of abuse or neglect of minors or vulnerable adults. I understand that state and local laws require that my psychologist report all cases in which there exists a danger to self or others (e.g. potential for suicide or homicide).

I understand that there is no assurance that I will feel better and no representation is made that any individual, including myself, will improve from treatment. Because psychotherapy and biofeedback are cooperative efforts between the client and his/her therapist, I will work with my therapist in a cooperative manner to resolve my difficulties. I understand that treatment involves the learning of new skills and a consistent investment of time, effort, and practice. I understand that clients see the best results and improvements, including maintenance of these changes, when learning is practiced and reinforced frequently, especially in the beginning stages of treatment. Therefore, I understand that, in order to maximize the effectiveness of training, Mind Flex may recommend up to two sessions per week. Moreover, I understand that I should make efforts to make and keep appointments and to be consistently ready and motivated. I further understand that homework, such as practicing relaxation methods (deep breathing, relaxation tapes, etc.) is integral to the treatment process and should be practiced frequently and regularly. I understand that during the course of my treatment, material may be discussed which may be upsetting in nature and that this may be necessary to help me to resolve my problems. I understand that it is my responsibility to monitor the subjective effects of training and to continue treatment so long as benefit is perceived. I understand that different individuals progress with treatment at different rates and with different styles and that the research literature indicates that there are some individuals who are apparently unaffected by treatment. Accordingly, I understand that I am encouraged to evaluate progress after a minimum of twelve sessions to determine if further treatment is indicated. Furthermore, I understand that communication with my psychologist is invited and strongly encouraged at this point or at any time during the treatment process. Furthermore, if I am considering or planning to terminate treatment, I am encouraged to discuss the factors contributing to my concern or decision. I understand that my feedback is essential for promoting and insuring the quality of care and service that I deserve. I understand that if my condition deteriorates or other difficulties arise that are beyond the competency and training experience or resources of providers at Mind Flex, my psychologist will work with me to find a more appropriate therapist or may refer me for psychiatric consultation.

I understand that some individuals have reported that biofeedback training may affect one's response to medication. I understand that I should not stop or alter any of my medications without consulting my physician/psychiatrist. I understand that I should continue ongoing therapies until otherwise advised by my physician. Should new symptoms develop, it is my responsibility to inform my health care providers including Mind Flex. I further understand that the therapists at Mind Flex are not medical doctors and cannot prescribe medication or change dosage levels for any of my conditions.

I understand that the therapists are either licensed practitioners or working under the supervision of licensed practitioners in compliance with licensure laws.

***FOR CLIENTS SEEKING/CONSIDERING BIOFEEDBACK TRAINING***

I understand that biofeedback is used for a variety of conditions which appear to be associated with irregular nervous system activity, including but not limited to sleep disorders, depression, anxiety, and chronic pain. I understand that training is recommended on the basis of empirical observation of improvement in clients with similar conditions. I understand that biofeedback training requires placement of sensors on my ear/finger for the purpose of recording my HRV (heart rate variability) and the use of this signal is to provide video displays and audio signals. I understand that the training is noninvasive and appears to be a harmless procedure as far as is known at present, and no injuries are known or reported in the traditional biofeedback literature. I understand that there is some indication that in a few cases, improvement may fall off after the cessation of training, and that these individuals would benefit from periodic follow-up or booster sessions.

## ***Confidentiality***

I understand that records and information collected about me will be kept in utmost confidentiality according to Federal and State law and professional and ethical guidelines, except in cases mandated by law. However, I understand that use and disclosure of my protected health information (PHI) will be limited to the minimum necessary for Treatment, Payment, and Operations. Furthermore, I have received, read, understand, and consent to the general guidelines outlined in Mind Flex LLC *Notice of Policies and Practices To Protect The Privacy of Your Health Information (effective date April 14, 2003)*. I understand that all information will be revealed only on an as needed basis and will be held in utmost confidentiality.

I understand that there may be publication and/or other educational uses (such as case studies for a particular disorder included) of the efficacy data collected during my treatment. I understand that any identifying information will be deleted and that no information that identifies me will be released without my separate consent except as specifically required by law.

## *Mind Flex LLC*

## ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

***Patient Name*** _____

I hereby authorize the release of the minimum necessary protected health information to process insurance claims for mental health services provided to me or my dependent by the mental health professionals of Mind Flex LLC

I hereby authorize payment of benefits directly to Mind Flex LLC such allowable professional services as may be provided me or my dependent according to my current insurance policy.

I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred by the above-named patient, and I agree that I am financially responsible to make payment in full on remaining patient balances should my insurance carrier determine that the services I or my dependent received are not covered***. I also understand that Mind Flex LLC extends a professional courtesy of checking benefits information, (deductible, co-pay, co-insurance) BUT this does not exempt me as the insurance subscriber from financial responsibility, should said information contradict actual coverage as identified by my (EOB) Explanation of benefits.***

I understand that I have the right to confirm the mental health benefit information provided by my insurance carrier that was quoted to Mind Flex LLC

A xerox copy of this authorization shall be considered as effective and valid as the original.

_____

***Signature of policyholder*** ***Date signed***

_____

***Signature of claimant, if other than policyholder*** ***Date signed***

## ***Scheduling and Cancellation Policies***

We make every effort to meet all of our clients' scheduling needs; however, we recommend that in order to reserve times, clients schedule appointments in advance. Clients will be called by our office to confirm. Since our service is weekly, last minute cancellations place clients who are waiting for an appointment at a disadvantage. If appointments are cancelled or rescheduled in a timelier manner, we can help to ensure more effective treatment for all of our clients.

Clients who cancel with *less than 24 hours notice*:

- Will be charged $125.00, the reasonable and customary amount for the session.
- Clients will be billed and are wholly responsible for these charges.

Similarly, we encourage rescheduling of missed or canceled appointments (even if 24 hours notice was given) so that treatment benefits are maximized.

By signing this form, I indicate my understanding of the principles and policies set forth here in this *Informed Consent* Document and waive any claim of damages due to treatment including worsening of my condition for which the treatment was undertaken, claimed side effects, or the failure to improve with training/treatment. I agree to submit any dispute with Mind Flex to binding arbitration under the rules of the American Arbitration Association. I understand that an electronic copy of this authorization and consent shall be considered as effective and valid as the original.

***I have read this document in its entirety and have had the opportunity to have my questions answered to my satisfaction. I understand and fully agree to abide with all of the above policies and statements. I have received a copy of this policy.***

***Client/Patient Name (Printed)*** _____

_____ _____
***Signature of Patient/Client*** ***Date***

_____ _____
***Signature of Parent, guardian or authorized representative (when required)*** ***Date***

_____ _____
***Signature of Psychologist*** ***Date***

## *Mind Flex LLC.*

I _____ have read and received a copy of Mind Flex LLC's, Notice of Privacy Practices.

This constitutes a receipt of the Notice of Privacy Practices written acknowledgement form.

_____ _____
***Signature of client/parent*** ***Date***

# *MIND FLEX LLC*
# *NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION*

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by federal law (Health Insurance Portability and Accountability Act, or HIPAA, U.S. Congress) to maintain the privacy of your Protected Health Information ("PHI"). PHI is personal information about you, including demographic information that we collect from you, that may be used to identify you and relates to your past, present, or future physical or mental health or condition, including treatment and payment for the provision of healthcare.

This Notice explains our legal duties and privacy practice with regard to your PHI. We are required by federal law to provide you with a copy of this Notice and to abide by the terms of this Notice. Accordingly, we will ask you to sign a statement acknowledging that we have provided you with a copy of the Notice. If you have elected to receive a copy electronically, you still have the right to obtain a paper copy upon request.

## I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

We intend to limit the disclosure of your PHI to that necessary for *Treatment, Payment, and Operations*. Although Federal Law states that I do not need your written authorization to use or disclose your PHI for treatment, payment, or health care operations, our professional code of ethics states that we do, and you will therefore by asked for your written authorization even though it is not legally necessary.

- ***Treatment*** refers to specific sharing and use of your PHI relating to your direct care (provision, coordination, and management) by our employees, including consulting other professionals and the use of disease management programs. For example, we will disclose your PHI to another health care professional, such as your family physician or another psychologist, or a testing facility to which you have been referred for care or for assistance with treatment.

- ***Payment*** refers to specific sharing and use of your PHI for purposes of obtaining payment for our treatment of you, including billing and collection activities, related data processing and disclosure to consumer reporting agencies. For example, your PHI will be disclosed on forms we submit to your insurance to obtain reimbursement for your health care or to determine eligibility receive payment.

- ***Operations*** refer to specific sharing and use of your PHI necessary for our administrative and technical operations, within the limitations imposed by professional ethics. Permissible activities would include, but are not limited to, accounting or legal activities, quality assessment and improvement activities, case management, care coordination, employee review, student/intern training, and other business activities such as audits and administrative services. For example, we might need to disclose your PHI to an intern as part of the educational process.

- ***Use*** applies only to activities within our office (clinic, practice group, etc.) such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

- ***Disclosure*** applies to activities outside our office (clinic, practice group, etc.) such as releasing, transferring, or providing access to information about you to other parties.

## II. USES AND DISCLOSURES REQUIRING AUTHORIZATION

An authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, and operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that 1) we have relied on that authorization; or 2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

***Psychotherapy notes*** are notes recorded (in any medium) by a healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a private, group, joint, or family counseling session. These notes are considered to be highly confidential in nature and the psychotherapist-patient privilege requires heightened level of concern regarding the privacy of the information contained in the notes. Since psychotherapy notes are often used only by the therapist who wrote them and are maintained separately from the medical record it is necessary to use a separate authorization for this request.

Psychotherapy notes DO NOT include the following:

- Medication or prescription records,
- Monitoring or counseling session start and stop times,
- Modalities and frequencies of treatment furnished,
- Results of clinical tests, and
- Any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date

This information would be included in your general treatment record, and would be available for treatment, payment, and healthcare operations, restricted by the "minimum necessary" provision for payment and healthcare operations.

Your refusal to provide such authorization will not affect our duty to treat you. Such authorization cannot be compelled for payment, underwriting, or plan enrollment. (Health plans cannot condition enrollment, eligibility for benefits, or payment of a claim on obtaining a person's authorization to use or disclose psychotherapy notes.)

We must obtain individual (not to be combined with another authorization) written authorization for the disclosure of psychotherapy notes for all requests EXCEPT for the following reasons:

- Use by the originator of the psychotherapy notes for treatment;
- Use or disclosure by the covered entity in the professional training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling;
- Use or disclosure by the covered entity to defend a legal action or other proceeding brought by the patient;
- Use or disclosure of psychotherapy notes by an oversight agency such as the Secretary of Health and Human Services, or any other officer or employee of the Department of Health and Human Services to whom the authority has been delegated, to conduct enforcement activities;
- Use or disclosure needed for oversight of employees of covered entity who created the psychotherapy notes
- Use or disclosure needed by a medical examiner or coroner for the purpose of identifying a deceased person, determining the cause of death, or other duties as authorized by law; or
- When we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

We will not permit the following disclosures without your written authorization:

- Marketing
- To your employer, except where necessary for provision of care or payment purposes (for example, if your employer is self-insured).
- Disclosures outside our offices, unless for treatment, payment, or operations.
- For research purposes, unless certain safeguards are taken.

## III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

We may make disclosures in certain situations as required by law, even without your written authorization. These situations include, but are not limited to:

- **De-identified PHI**--If all identifying information is removed so your identity cannot be ascertained from the information disclosed, i.e., on a completely anonymous basis
- **Public health authority** as required by law.
    - **Child Abuse**--We are required to report PHI to the appropriate authorities when we have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.
    - **Adult and Domestic Abuse**—If we have the responsibility for the care of an incapacitated or vulnerable adult, we are required to disclose PHI when we have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.
    - **Serious Threat to Health or Safety**--If you communicate to us an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and we believe you have the intent and ability to carry out such a threat, we have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If we believe that there is an imminent risk that you will inflict serious harm on yourself, we may disclose information in order to protect you.
    - When required by law, for example, public health reporting purposes or to a person who may be affected by a communicable disease.
- **Health Oversight Purposes** as authorized by law, for example, an investigation of our practice by the Pennsylvania Board of Psychology for purposes unrelated to your treatment.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law, and we will not release this information without written authorization of you or your legally appointed representative or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Worker's compensation law**--(or a similar law). For example, if you file a worker's compensation claim, and we are treating you for the issues involved with that complaint, we may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault. Similarly, we may disclose PHI to your employer, if we are providing care to you at your employer's request to evaluate a work-related illness or injury, or medical surveillance of your workplace.
- To law enforcement for certain purposes, including pursuant to a warrant or court order.
- To the U.S. Food and Drug Administration, in the event of an adverse event.
- For national security and intelligence purposes, military or veteran's activities, or to correctional institutions.
- Decedents--To coroners or funeral directors regarding deceased individuals

## IV. PATIENT RIGHTS

You have six rights as a patient of Mind Flex LLC:

1. ***The right to consider and sign an authorization for a non-authorized use***. The law only allows us to use or disclose your PHI in certain circumstances, as explained above. If we need to make a use or disclosure that does not fall into one of those exceptions—including the disclosure of psycho-educational records to schools or results of psychological evaluations to employers—we will ask you to sign an authorization. If we do not have a valid authorization on file specifically authorizing the proposed use or disclosure, then we will not make that use or disclosure. You may revoke an authorization at any time in writing, but the revocation will not apply to uses or disclosures that we have already made in reliance on your original authorization.

2. ***The right to access your PHI***. You have a right to access and receive a copy, summary, or explanation of your PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We have the right to deny you access under certain circumstances, such as psychotherapy notes, information compiled in reasonable anticipation of legal action, and confidential information relating to certain lab tests, but you will be notified of the reason for denial and be given the right to have the denial reviewed under certain circumstances.

3. ***The right to request restrictions on certain uses and disclosures.*** You may request restrictions of certain uses or disclosures of your PHI when it is used to carry out your treatment, obtain payment for your treatment or to perform healthcare operations of our practice. You must request the restriction before we have used or disclosed the relevant information. *We are not required to agree to the restriction, and we have the right to decide not to accept the restriction and not to treat you.*

4. ***The right to receive confidential communications.*** You may request that we make confidential communications to you by an alternative means or at an alternative location. The request must be in writing, but we will not ask for an explanation from you. We will accommodate reasonable requests, but we may condition the accommodation on information as to how payment, if any, will be handled and specification of an alternative address or other method of contact. For example, you may not want a family member to know that you are being seen by us. Upon written request, we will send your bills or contact you by an alternative address or method.

5. ***The right to amend PHI.*** You have the right to ask to request an amendment of PHI for as long as the PHI is maintained in our record. We have the right to deny your request for amendment, if we determine that your record was not created by us, is not maintained by us, would not be available for access, or is accurate and complete. Your records will not be changed or deleted as a result of our granting your request, but the amendment will be attached to your record and its existence noted in your record as necessary. (Note: use of this procedure is not necessary for routine changes to your demographic information, such as address, phone number, etc.)

6. ***The right to receive an accounting.*** You have the right to receive an accounting of our uses and disclosures of your PHI. You will need to complete this form and submit it to us. The accounting does not have to list disclosures made (i) to carry out treatment, payment and healthcare operations; (ii) to you; (iii) pursuant to an authorization; (iv) for national security or intelligence purposes; (v) to correctional institutions or law enforcement personnel or (vi) that occurred prior to April 14, 2003. (Note: compliance with this right is time-consuming, and so we reserve the right to charge you a fee if your request more than one accounting in a twelve-month period.)

## V. PSYCHOLOGIST'S DUTIES

- We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. The change may be retroactive and cover PHI that we received or created prior to the revision. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we do change the Notice, a copy of the new Notice will be posted in the waiting room and on our website, if any. We will provide you with a copy of the revised Notice upon your request.

## VI. ORGANIZATIONAL POLICIES

To facilitate the smooth and efficient operation of our practice, we engage in certain practices and policies that you should understand. You can avoid any of the following practices by discussing your concerns with us and working out an alternative:

- We contact our patients by telephone (which might include leaving a message on an answering machine or voice mail) or mail to provide appointment reminders or routine test results.

- We may contact our patients by telephone or mail to provide information about treatment alternatives or other health-related benefits and services that may be of interest.
- We may use your name and address to send you a newsletter about our practice and the services that we offer.
- We may disclose your PHI to a member of your family or a close friend that relates directly to that person's involvement in your healthcare.

You should also be aware of the following policies regarding our uses and disclosures of your PHI. You cannot avoid these uses and disclosures, but you should discuss any questions or concerns you might have with us:

- We share PHI with third-party "business associates" that perform various function for us (for example, billing and transcription), but we have written contracts with those entities containing terms that require protection of your PHI.
- We may disclose your PHI to your personal representative(s), if any, unless we determine in the exercise of our professional judgment that such disclosures should not be made.

## VII. QUESTIONS AND COMPLAINTS

If you have any questions about this Notice, the matters discussed herein or anything else related to our privacy policy, please feel free to ask for an appointment to speak with our Privacy and Security Officer.

You may complain to our Privacy and Security Officer or the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. To complain to the Secretary, your complaint must be in writing, name us, describe the acts or omissions believed to be in violation of your privacy rights and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will not retaliate against you for filing a complaint. If you want further information about the complaint process, please talk to your Privacy and Security Officer.

## VIII. EFFECTIVE DATE

This notice is in effect as of April 14, 2013.