PHILADELPHIA
INTEGRATIVE PSYCHIATRY

Philadelphia Integrative Psychiatry
400 Lancaster Ave, Devon PA 19333
Phone: 610-999-6414 Fax: 888-960-2779
www.PhillyIntegrative.com

Consent for Treatment; Consent to Use and Disclosure of Health Information; Clinical Policies and Procedures; Consent to Electronic Communications; and Acknowledgement of Receipt of Notice of Privacy Practices

Welcome to DMD Endeavors LLC, d.b.a. Philadelphia Integrative Psychiatry (the "Practice", "we", "us" or "our"). You must review and complete this form before the Practice can provide professional services.

1 CONSENT FOR TREATMENT:

The individual signing this form ("you") hereby consents as or on behalf of the patient named above (the "Patient") to permit the Practice through its psychiatrist(s), psychologist(s), physician assistant(s), counselor(s), nurse practitioner(s), nurse(s), and other staff to provide diagnostic and other behavioral health care and treatment to the Patient that is medically reasonable and necessary in the professional judgment of the Practice's professional staff, which may include, among other things, receiving and participating in psychiatric evaluations, individual / group / family psychotherapy, pharmacotherapy, and/or crisis intervention. Further, you consent for the Patient to receive a comprehensive diagnostic assessment, after which you, the Patient, and the Practice will mutually determine whether to continue treatment. Finally, you consent to treatment in the care setting agreed-to by both you and the Practice which may include the Practice's office, your home, a school setting, and/or virtual (*e.g.*, telephone or secure video conference).

2 CONSENT TO USE AND DISCLOSE HEALTH INFORMATION:

You hereby consent to the Practice's use and disclosure of medical information in Practice's possession concerning the Patient's behavioral health treatment that may identify you and/or the Patient and be considered "protected health information" to: a) the Practice's workforce, including employees, contractors, trainees, and volunteers, and any other health care provider involved in the Patient's care for purposes of providing treatment to the Patient; b) the Practice's workforce and other permitted parties for purposes of the Practice's health care operations; and c) any other permitted purpose for which the Practice is not required to obtain a separate, express authorization, as permitted or required by applicable state and federal laws and regulations.

3 CLINICAL POLICIES AND PROCEDURES

Telephone Communications: To safeguard the Patient's protected health information, the Practice will only leave messages regarding the Patient's medical and billing information at the phone number(s) on record, your patient portal, through the Spruce text or App, and/or your email address on record. When leaving a message or speaking with another person regarding the Patient's care, the Practice will limit the information disclosed to the minimum that is necessary.

This consent is not valid to permit use or disclosure of the Patient's protected health information for a purpose that requires an authorization under the HIPAA Privacy Rule (45 CFR § 164.508), or where other requirements or conditions exist for the use or disclosure of the Patient's protected health information under state laws and regulations.

Telepsychiatry: Telepsychiatry includes both video and telephone interactions during which psychiatric and/or therapeutic care is provided. Telepsychiatry provides psychiatric and therapy services using HIPAA-compliant interactive video conferencing tools in which the psychiatrist/therapist and the patient are not at the same location. Telephone calls without video may be used for cases when video is not viable or preferred, and in-person sessions are not feasible. Telepsychiatry will allow the patient to receive psychiatric and therapeutic care without the need to visit the office and travel long distances.

- Your rights with regards to telepsychiatry:

○ The laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry;

○ The various forms of telepsychiatry we employ are known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

○ You have the right to withdraw your consent to the use of telepsychiatry during the course of your care at any time.

○ The Practice has the right to withhold or withdraw consent for the use of telepsychiatry during the course of your care at any time;

- Potential risks include, but may not be limited to:

○ Information transmitted may not be sufficient (poor resolution of video);

○ Delays in medical evaluation and treatment due to deficiencies or failures of the equipment;

○ Security protocols can fail, causing a breach of privacy; and

○ A lack of access to all the information available in a face to face visit may result in errors in medical judgment.

- Alternatives to telepsychiatry include traditional face to face sessions.

- Patient's Responsibilities

○ You will not record any telepsychiatry sessions without written consent from us. Similarly, we will not record any of our telepsychiatry sessions without your written consent.

- You will inform your provider if any other person can hear or see any part of our session before the session begins. Similarly, the provider will inform you if any other person can hear or see any part of your session before the session begins.

- You agree to use a private and secure network if accessing the internet for a telepsychiatry session and to remain in a private setting so others cannot hear or see you.

- You agree that you will be physically located in Pennsylvania during your telepsychiatry session.

- You, not your provider, are responsible for the configuration of any electronic equipment used on your computer or phone that is used for telepsychiatry. You understand that it is your responsibility to ensure the proper functioning of all electronic equipment before your session begins.

Emergencies: The Practice is not available after hours or on holidays and weekends and is not considered an emergency resource. If there is a potential of any physical danger to you, the Patient, or others, you shall call 9-1-1 immediately, go to the nearest emergency room, or call a crisis hotline (such as the National Suicide Hotline at 800-784-2433). After the Patient receives emergency attention, you shall contact the Practice as soon as is feasible at 610-999-6414.

You agree that if you require emergency treatment during a scheduled session and the applicable health care provider determines, in their professional judgment, that an attempt to secure consent to treatment would result in delay of treatment which would increase the risk to your life or health, that no further consent to treatment will be necessary in such circumstance. You understand that the Practice's staff will work to inform your emergency contact person as soon as practicable in the event of such an emergency. You also understand that to the extent permissible pursuant to applicable privacy laws, your health care information may be disclosed in connection with the provision of emergency treatment.

Collaboration with other Healthcare Practitioners: It is essential for the Practice to communicate and share records with the Patient's current and recent healthcare providers. This is to help establish a more accurate diagnosis, provide therapeutic collaborative care, foster effective coverage in a provider's absence, and decrease the chance for medication errors. Such practitioners include, but are not limited to, inpatient psychiatric practitioners, covering practitioners, primary care physicians, current therapists, any other mental health practitioners the Patient may have seen within the past year, and the Patient's pharmacists. By signing this form, you consent to allow the Practice and its practitioners to disclose and share your medical information for purposes of treatment and coordination of care. The Practice requires access to the Patient's prescription history over the past year to decrease the chance for double prescribing and other prescribing errors (there is nothing to do on your end in this regard).

Medication Management: If the Patient is receiving medication management with our staff, we require **visits at a minimum of every three months**. If the Patient is not willing to be seen at the frequency the staff feels is necessary for the Patient's safety and mental health stability, then the Practice reserves the right to terminate the treatment relationship and assist in the transition of the Patient's care to an appropriate medical professional. Add initials here for consent.

Medication Refills: It is your responsibility to contact the Practice if the Patient needs additional medication before the Patient's next visit. The Practice will only refill medication if the Patient is active in treatment. The Practice may refuse to give a refill if the Practice has not seen the Patient recently and the Practice feels that an office appointment is clinically indicated. Please allow up to three business days to process refill requests. Refills are not processed over weekends or holidays. If prior authorization is required, it is the Patient's responsibility (not the pharmacy's) to get in touch with the Practice. The Practice requires five business days to attempt to get authorization (most of the time it is in the insurance company's hands as to how quickly this can be processed). The practice charges an administrative fee for prior authorizations at a rate of $30/hour, broken down into 15 minute increments.

Coverage: If the Patient's scheduled psychopharm provider is unavailable, the Practice will provide appropriate coverage by a psychiatrist, nurse practitioner, or physician assistant. Please see the "Emergencies" section, above, related to emergencies occurring outside of the Practice's business hours, which are currently Monday through Friday, 9:00 a.m. to 5:30 p.m., but are subject to change.

Minor Patient Caretaker: You are the legal guardian of the Patient, a minor child who under the age of 14 is unable to consent for their own mental health treatment under Pennsylvania law, and you designate and authorize a caretaker to bring the minor Patient to the Practice for scheduled appointments for behavioral health care and treatment in which you previously consented be provided to the minor Patient. You understand that only a legal guardian may consent to treatment for the minor Patient, by signing this contract.

Commitment/Duty to Warn: Pennsylvania law gives mental health practitioners, including the Practice and certain of its professional staff, the right to commit the Patient to an inpatient psychiatric unit if the mental health practitioner believes that the Patient is a danger to themselves or others, even if the Patient and/or you disagrees. Additionally, this practice and its practitioners bear the responsibility in warning any individual that is at immediate risk of harm by one of our patients. This policy aligns with state and federal "duty to warn and protect" laws that govern all mental health practitioners.

Mandated Reporter: As healthcare providers, the Practice is required, by law, to make a report of suspected child abuse if they have reasonable cause to suspect that a child is a victim of child abuse. It is not required that the child come before the mandated reporter in order to make a report of suspected child abuse nor are they required to identify the person responsible for the child abuse to make a report of suspected child abuse.

Forensic Services and Disability Determinations: The Practice does not provide forensic services such as custody evaluations, assessments recommended by probation, ability to stand trial, etc.

Recordings: Audio and/or video recording by you and/or the Patient of any session at the Practice is prohibited. If an unauthorized recording is made, it is grounds for the Practice to terminate the treatment relationship.

Note Taking Technology: We uphold a legal and ethical duty to the utmost to safeguard all communications stemming from our appointments. To enhance the quality of care we offer, we may use a specialized, HIPAA-compliant note-taking system that provides automated transcripts and summaries of our interactions. This system employs state-of-the-art encryption, firewalls, and backup measures to help secure your personal information. By proceeding with our appointments, you are giving your consent for us to utilize this note-taking technology.

- Details

  - Transcription and Summarization: The conversations from our appointments will be transcribed and summarized using HIPAA-compliant technology. No recordings are stored by the system. These summarized notes may be included in your confidential medical records.

- Risks and Benefits

  - Risks: Any use of technology carries an inherent risk of unauthorized disclosure. You can bolster the privacy of our communications by using secure, trusted networks and password-protected devices for our appointments.While names and other identifiers are removed, researchers associated with the technology will have access to de-identified session transcripts. It's possible that the system may contain unintentional biases in the summarization process. This risk is offset by our ongoing commitment to carefully review and edit notes using our clinical expertise.
  - Benefits: The automated system allows us to dedicate more attention to the appointment process. It eliminates the need for manual note-taking, thereby aiding memory and focus during and after our appointments.This technology helps in reducing our workload, which could potentially alleviate professional fatigue on our end. The system might offer additional clinical insights that could positively influence the outcomes of our appointments.

By proceeding with appointments, you acknowledge and accept these terms.

Discontinuation of Treatment: The Practice may discontinue treatment with the Patient only after a reasonable amount of discussion and usually for one of the following reasons: (1) Canceling/missing appointments too often; (2) Non-compliance with treatment recommendations; (3) Lack of cooperation by individuals such as parents or legal guardians who are authorized (by the Patient or in accordance with applicable laws and regulations) to participate in the Patient's treatment; and (4) Other reasons include inappropriate / unprofessional behavior, concerns regarding safety, misuse of medication, or lack of compliance with treatment or payment. Additionally, unless otherwise notified by you or the Patient, the Practice will assume that the Patient's treatment relationship with the Practice has terminated ninety days after the Patient's last visit unless the Patient has an appointment scheduled for a

future date. Additionally, the Patient is considered terminated from treatment when clients come for an initial consultation and it is determined no medication management or ongoing psychiatric care is warranted. Upon termination of the treatment relationship, the Practice carries no further responsibility for the Patient's care. The Patient may re-enter treatment with the Practice at the Practice's discretion and, upon reentering, will be held to the initial signed Consents and, at the Practice's discretion, will be expected to go through either a 50 minute follow up appointment or a a new outpatient intake appointment, and pay those relevant fees.

4 CONSENT TO ELECTRONIC COMMUNICATION

Email & Text Communications: We attempt to make communication with our clinicians as easy and efficient as possible, which is why we employ SMS text, email, and app based communication. Based on this consent, the Practice shall use electronic communications, including email, SMS text messages, phone applications, and phone calls to communicate with you and the Patient including with regard to protected health information. This consent provides you with information about how we use these types of communications and the associated risks. It will also be used to document your consent to use these types of electronic communications to communicate with you, the Patient, or others you may designate above. You hereby agree to create an account or otherwise sign up with such vendor, at no cost to you or the Patient, in order to receive and send electronic messages (text, email, and application based messaging) and receive phone calls. However, text and email or, by nature, not completely secure. We therefore ask for the Patient's consent to employ email or standard SMS messaging regarding various aspects of the Patient's medical care, which may include, but shall not be limited to, test results, prescriptions, medication ideas, side effects, appointments, and billing. The patient understands that email and standard SMS messaging are not confidential methods of communication and may be insecure. The patient further understands that, because of this, there is a risk that email and standard SMS messaging regarding their medical care might be intercepted and read by a third party.

You will have the same access rights to this portion of the Patient's medical record as you do to the rest of the Patient's record, as described in the Practice's Notice of Privacy Practices. The Practice may forward electronic communications among the Practice's staff for purposes of the Patient's diagnosis, treatment, or other permitted purposes. When the Practice collaborates with Your other health care practitioners, the Practice will either use a fax or password protected documents when emailing your protected health information. Please review the Notice of Privacy Practices for information about permitted uses of the Patient's protected health information and your rights regarding the confidentiality of this information.

Risks: Electronic communications, including SMS text messages, emails, and voicemails can be forwarded, circulated, stored electronically, or broadcast to many intended or unintended recipients. Electronic communications and voicemails can be forwarded to other recipients, altered, or intercepted without the original sender's permission or knowledge. Electronic communications can be easily misaddressed. Backup copies of electronic communications often exist, even after the sender and/or recipient has deleted the original version. Employees do not have an expectation of privacy at their place of employment, and employers and online services can inspect the communications sent through their company systems. We recommend that you and the Patient do not use an employer's email system or employer-issued electronic devices to

send or receive confidential medical information. Electronic communications may not always be secure, so it is possible that a third party may breach the confidentiality of these communications. Although the Practice will use reasonable and appropriate means to protect the security of the Patient's protected health information, it cannot guarantee the security and confidentiality of electronic communications.

Your Responsibilities: If you provide your consent to use of electronic communications, it is your responsibility to do the following. Call 9-1-1 if the Patient is experiencing a medical emergency – do not use electronic communications with the Practice in this situation. Inform the Practice's staff of any specific information you do not want communicated via electronic communications. Protect passwords or other means of accessing the electronic communications sent by or to you or the Patient related to the Practice. Follow up with the Practice if you have not received a response to your or the Patient's electronic communication within two business days, to determine whether the intended recipient has received it and to inquire about an expected response time. Notify us immediately of any changes to your preferred mobile telephone number or email address.

Applicability of Provisions: Depending on the nature of the services provided to you by the Practice and its providers and the setting in which such services are rendered (which may include in the Practice's office, at the patient's home, in a school setting, and virtually), you acknowledge that certain provisions of this consent that are related to specific services or specific settings may not be applicable to you.

5 **CONTROLLED SUBSTANCE POLICY:**

Controlled substance use by prescription: This office uses prescribed controlled substances for the treatment of various mental health diagnoses. Most commonly prescribed controlled substances are stimulants for ADHD which are categorized as a schedule 2 controlled substance by the federal government, meaning they present risk for abuse and dependence. This Practice generally avoids prescribing benzodiazepines, which are schedule 4 controlled substances, although this Practice may occasionally use benzodiazepines for intermittent treatment of specific situations that bring on high anxiety, i.e. needle phobias or intense fear of flying. This Practice prescribes controlled substances with great care, and will only prescribe these medications to patients who adhere strictly to the below policy. The Practice shall only prescribe controlled substances in accordance with applicable laws, regulations, and rules including, without limitation, those provisions of the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 applicable to health care providers.

Signature of this form indicates that you agree to the following contract for the administration of and treatment with controlled substances, should those be prescribed to you.

- I agree to only take my medication(s) as prescribed. This includes how often I take the medication(s) and what dose I take.
- I have disclosed all of my medications, supplements, and vitamins to my provider. I am responsible for updating my provider with any changes to this list.
- I understand that the medications that I am being prescribed have abuse potential – and that being prescribed this medication puts me at risk for developing a substance abuse problem. I also understand that this medication may cause physiological dependence, tolerance and withdrawal.
- I understand that the Practice may require random drug testing while under their care. Results that are inconsistent with my medical history or medications prescribed or results suggesting that I may have a substance problem (for example testing positive for illegal drugs or medications that I am not prescribed), may be grounds for termination of care at my provider's discretion.
- I understand that I always have the right to refuse or stop taking my medication(s), but that doing so may result in withdrawal symptoms (with potentially severe medical consequences including, in the case of benzodiazepines, seizures and, in rare cases, death). If I decide to stop a medication or decrease my dose without direct supervision from my provider, he/she/they are not responsible for any serious adverse reaction or consequences (including seizure and/or death).
- If there is concern for medication abuse, diversion (giving or selling the medication to others) or "doctor shopping" (obtaining similar medications from multiple prescribers), my care will be terminated at my provider's discretion. Signing this form gives my provider permission to share my medical record (including drug screens) with any law enforcement agency, medical provider and pharmacy if my

provider has a concern. The Practice and its providers are not responsible for any legal repercussions that I incur, should this occur.

- The Practice may contact all of my current and previous providers and pharmacies at their discretion. Reasons include (but are not limited to) notifying them of this contract.

- The Practice may require periodic and/or random drug testing for those prescribed controlled medications.

- Refill policy – There are no early refills allowed on prescriptions for controlled substances. Should you have your medication stolen, a valid police report must be presented to your prescriber in order for a refill to be considered. There are no early refills for lost or damaged medications.

- As a general rule, the Practice avoids prescribing benzodiazepines, as they have been shown to potentially increase the risk of Alzheimer's, can be addictive, and can reinforce anxiety. Potential exceptions to this general rule include prescriptions for detox purposes, very infrequent use (*e.g.*, once per month for fear of flying), and other rare circumstances.

- If I am not adherent to this contract, honest about my medications and/or doses, do not take medications as prescribed, am not honest with my provider about a history of substance abuse or dependence, or do not notify my prescriber should I have concern that I am developing a substance abuse problem, I am solely responsible for any adverse outcomes.

6 **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

You hereby confirm that the Patient has been provided with a copy of the Practice's current Notice of Privacy Practices before signing this document (the first of the 3 agreements in this group of files, which you initialed above). The Notice of Privacy Practices describes the types of uses and disclosures of the Patient's protected health information that will occur for the Patient's treatment, payment of my bills or in the performance of healthcare operations of the Practice and the Practice's duties regarding the Patient's protected health information. The Notice of Privacy Practices also describes the Patient's rights with respect to the Patient's protected health information and how the Patient may exercise these rights. The Practice reserves the right to change the practices described in the Notice of Privacy Practices. The Patient may obtain a revised Notice of Privacy Practices by calling Practice's office and requesting a revised copy. By signing below, you acknowledge receipt of the Notice (on behalf of the Patient, as applicable).

I HAVE READ AND I UNDERSTAND AND ACCEPT THE TERMS AND CONDITIONS OF THE CONSENTS, POLICIES, PROCEDURES, AND DISCLOSURES SET FORTH ABOVE.

Print Name of Patient **Date**

Signature of Patient or Responsible Party

Relationship of Responsible Party to Patient (Self, Parent, etc.)

Patient Financial Responsibility Policies and Procedures

DMD Endeavors LLC, d.b.a. Philadelphia Integrative Psychiatry (the "Practice", "we", "us" or "our") is dedicated to providing you with quality patient care and is also aware that financial concerns are important to you. This Patient Financial Responsibility Policy is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs. By signing below, you acknowledge and agree to the following:

7 APPOINTMENT POLICIES AND PROCEDURES

Late Cancellation Fee: We are happy to accommodate you and your behavioral health needs and reserve a time in your provider's schedule just for you. However, in consideration of others, we have established the following cancellation policies. We understand that there are circumstances that may prevent you from keeping your appointment, but once a patient has been given a time slot, canceling on short notice does not give us adequate time to schedule another patient in need of treatment. We price our appointment slots as if all patients keep their appointments. Thus, it would be unfair to other patients if they were charged a higher rate to make up for those who do not show up. Similarly, practitioners at the Practice only get reimbursed when the patients keep their appointments. Accordingly, please review the following policies carefully. The main message is that **you must cancel at least 48 business hours in advance to avoid a late cancellation fee:**

- Business days are Monday through Friday. Business hours are currently until 5 pm, but are subject to change. Canceling an appointment after 5:00 p.m. on any business day (via electronic message, voicemail, or text message) is equivalent to canceling at 8:00 a.m. the following business day. For example, if you are a new patient with an appointment scheduled for a Monday at 3:30 p.m. and you cancel the appointment any time from 3:31 p.m. on the preceding Thursday to 3:30 p.m. until the day and time of the appointment, there will be a full late cancellation fee, typically the full cost of the appointment, or the loss of the deposit for new evaluations.

- There will be no charge to any patient for canceling an appointment 2 business days (48 business hours) or more before the appointment.

Please understand that this policy is not meant to be punitive and, of course, we try to work with patients in extreme circumstances; we give one exception per year for medical illnesses or true emergencies in the family. The fees discussed above will be automatically charged to the credit card on file. Please note that charges for late cancellations or missed appointments are not eligible for insurance reimbursement.

We will also attempt to contact you using your preferred method of contact in order to reschedule the appointment. You will be required to remit payment in full of any outstanding late cancellation fees before we will reschedule your appointment. If we are unable to make contact with you for more than two weeks after a cancellation, the Practice reserves the right to terminate the treatment relationship. Please see the termination section in the clinical disclosures form provided.

8 PAYMENT POLICIES AND PROCEDURES

Payment and Fees: We accept payments via credit or debit card through a secure service called Square Payments (https://squareup.com/). Square Payments will securely store your credit or debit card information in their system.

- For new clients seeing the physician, we require a downpayment in advance of $500 to secure the appointment, paid through a link to Square Payments we will send you (the downpayment for the NP is $300). This is refundable for clients that cancel in accordance with our cancellation policies (see above for more on that).

- For follow up appointments, billing will occur automatically through the credit card saved in the Square Payments or Simple Practice. You can change your preferred card by contacting us at least 2 business days in advance of your appointment. If you notify us later than 2 business days, we cannot guarantee that the credit card on file will be changed in time for the next appointment payment.

We also accept cash in person (although we still require a deposit via CC that can later be refunded if cash is preferred). In addition to other fees discussed in this document, the Practice will charge a $35 administrative fee for any credit card chargebacks or disputes, in addition to the charges originally invoiced.

- **Charges for this practice will typically appear on your statement as : SQ* PHILA INT PSY**

Session Charges: Session fees cover the cost of the visit and paperwork associated with completing the visit. We will complete two occasions of filling out brief forms (five or fewer minutes) *or* brief phone calls (ten or fewer minutes) at no charge. The Practice will charge for any additional occasions and any time beyond those limits at the same rate as our twenty-five-minute follow-up appointment, in five-minute increments.

Balances and Collections: Balances more than thirty days past due are subject to a 10% monthly fee. Balances more than ninety days past may be submitted to a collection agency or law firm for collection efforts. If we need to send your account out for collection, you hereby agree to reimburse the Practice for the costs of collection, along with all other amounts due and owing by you.

Insurance: The Practice does not accept insurance and does not accept insurance payment assignment. This means that all charges submitted to you by the Practice must be paid by you directly to the Practice. The Practice believes that arranging its payment system in this manner provides many advantages not only to the Practice, but also to the patient. For example, the Practice is not restricted by any limitations that insurance companies often place on practices with regard to the length of sessions or the number of sessions per day. This allows our practitioners the flexibility to spend more time with you. If you would like to submit your charges to your insurance provider for reimbursement, the Practice will provide to you a detailed billing and payment statement that you may submit to your insurer. NOTE: THE BILLING AND PAYMENT STATEMENT WILL INCLUDE INFORMATION NECESSARY FOR

REIMBURSEMENT, INCLUDING THE RELEVANT BILLING CODE(S) AND DIAGNOSIS/DIAGNOSES. The Practice will not negotiate with your insurer or otherwise advocate on your behalf for reimbursement, but the Practice will reasonably cooperate with you in your efforts to obtain reimbursement. Whether a charge is reimbursed and the amount of any such reimbursement is determined by your agreement with your insurer.

Laboratory and Genomind Studies: At times the Practice will need to order laboratory studies. Please be aware that the cost of labs is not included in the Patient's visit charge and is your responsibility. Please be sure to check with your insurance carrier prior to getting labs to learn what percentage of the lab fees is covered. This varies by insurance company. The practitioners at the Practice have no financial affiliation with any laboratories or genetic testing companies. We often recommend these services but we are not responsible for any costs passed on to the patient.

Court appearances / legal letters of medical opinions: If the Practice is served with a subpoena or other request seeking or requiring an appearance in court or other proceeding by a member of the Practice's staff, the patient will be responsible for payment of applicable fees. For the Practice's psychiatrist, such fees include a $500 hourly fee for preparation, travel, and appearance. Fees also include costs of copying medical records, as permitted under applicable state or federal laws and regulations, clerical and administrative work, and all legal fees incurred by the Practice for the purpose of complying with the subpoena or record request.

Property Damage: In the rare case that a patient destroys or damages any physical property, the patient is responsible for paying in full for a replacement, or repair when replacement is not an option, of those items.

STATEMENT OF FINANCIAL RESPONSIBILITY: I understand that as the patient or responsible party (if applicable), I am personally responsible for the payment of treatment and care provided to me by the Practice whether or not: I have insurance; my insurer covers the Practice's charges; the Practice and/or I proceed with treatment; or my treatment with the Practice is successful, for which I understand there is not any guarantee. I am fully and personally responsible for the payment of all charges, fees, and expenses charged by the Practice.

I HAVE READ AND I ACCEPT THE TERMS AND CONDITIONS OF THESE PATIENT FINANCIAL RESPONSIBILITY POLICIES AND PROCEDURES.

Print Name of Patient **Date**

Signature of Patient or Responsible Party

Relationship of Responsible Party to Patient (Self, Parent, etc.)

Philadelphia Integrative Psychiatry
No Surprises Act

The purpose of this notice is to inform you of the *No Surprise Act* under section 27988B2(d)of the Public Health Service Act (PHS Act) and how consumers are protected from unexpected medical bills related to out-of-network service providers. This document describes your protections against unexpected medical bills. It also asks if you'd like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider before scheduling care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less. If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You are getting this notice because Philadelphia Integrative Psychiatry is not in your health plan's network and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. Getting care from this provider or facility will likely cost you more. If your plan covers the item or service you're getting, federal law protects you from higher bills when:

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you.

If you sign this form, be aware that you may pay more because:

- You are giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit.

Contact your health plan for more information. Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, you can explore your out of network benefits with your insurance plan to determine the percentage of reimbursement you are entitled to receive in the event you utilize an out of network provider.

Information regarding *Price Transparency* is located on our website at www.phillyintegrative.com. However PLEASE NOTE: Fees are subject to change from time to time during times of price increases. All patients will receive a memo regarding a price increase via the email on file.

I HAVE READ AND I ACCEPT THE TERMS AND CONDITIONS OF THE NO SURPRISES ACT:

Print Name of Patient **Date**

Signature of Patient or Responsible Party

Relationship of Responsible Party to Patient (Self, Parent, etc.)