CONDITIONS OF SERVICE/ CONSENT FOR TREATMENT INTEGRATION MENTAL HEALTH LLC (IMH)

Consent to Treatment: I voluntarily consent to medical/psychiatric treatment provided by the health care practitioner(s) at IMH. I agree to hold the health care practitioner(s) as harmless. I acknowledge that no guarantees have been made regarding the result of any treatment that has been rendered. Initial _____

Release of Information: I authorize IMH to release or disclose to insurance companies, third party payor or health care providers patient medical information pertaining to treatment received.

Initial_____

Assignment of Insurance Benefits: I assign benefits for services rendered at IMH payable to IMH, Susan Ponder/Susie/Suzie Ponder. I authorize IMH or any agency representing IMH in the filing and submission of insurance, including Medicare claim forms and such claim forms.

Initial _____

Financial Responsibility: I agree to pay all fees not covered by insurance, including deductibles, copays, co-insurance fees. I understand that deductibles, copays, co-insurance fees are due at time of service. Initial _____

No Show and Cancellation Policy and Fees: A No Show (NS) or Cancellation involves lack of notifying the provider and/or the person(s) scheduling appointment **within a 24 hour period during business hours.** Please be advised of the NS, Cancellation fee of **$65.00 for 30 minute** appointments, **$85.00 for 45 minute** appointments and **$100.00 for 60 minute** appointments. Emergency situations will be taken into consideration, and the NS, cancellation fee may be waived. **3 NSs may result in treatment termination.** PLEASE MAKE EVERY EFFORT TO KEEP APPOINTMENTS - THERE ARE MANY IN NEED WHO MAY BENEFIT WITH ADVANCE APPOINTMENT CANCELLATION NOTICE, THANK YOU

Initial _____

LATE FEES: I agree to pay IMH an interest rate of 10% for fees not paid within a 60 - 90 day period, followed by a 15% interest rate thereafter, with the risk of treatment termination and/or notification to a collection agency. If bills are not payed in full after 3 notifications, such bills/ invoices will go to

Collection Agency and are subject to attorney and court fees that the client will be fully responsible for such fees and payments

Initial _____

Current Controlled Substance Policy (Benzodiazepines, Sedative Hypnotic, Stimulant Medications):

IMH does not endorse daily and regular use of sedative, hypnotic medications. Continued daily/regular use may be determined on an individual case by case basis, based on gross benefit versus harm. Recommendations are for either short term and/or "PRN", "as needed", use based on each individual's clinical needs. Recommendations are for adjunct psychotherapy when daily sedative, hypnotic medications are prescribed.

The PDMP (Patient Drug Monitoring Programing) will be reviewed prior to all patients presenting with use of any medication considered "Controlled" and with any patient with self report of significant drug use.

Additionally, IMH, at the discretion of the healthcare practitioner(s), may opt to do a random, on site, urine drug test, at the expense of the client, for a fee of $12.50 , cash pay. Random urine drug testing may be done upon suspicion of illicit substance use, at the discretion of the psychiatric provider.

Individuals requiring stimulant medication(s) for the diagnosis of Attention deficit hyperactivity disorder or others disorders, and with a recent history of illicit substance use, may be required to do random urine drug screens. Initial _____

HIPAA Statement: I have read or opted out of reading of reading the HIPAA Authorization To Use and Disclose Health Information and I understand that I may request a copy. Initial _____

Credit Card Authorization:

I authorize IMH to bill the credit card (or HSA/FSA card) for payment of services. I certify that I am the person authorized to use the CC. I have agreed to provide my most current CC and insurance informations.

Initial _____

I authorize such above mentioned credit card (or HSA/FSA card) payments to IMH. Initial _____

I authorize such above mentioned credit card (or HSA/FSA card) payments to IMH. Initial _____

CC# :

Exp. Date:

3 digit cvs code:

Zipcode associated w/ CC:

Signature:

Date:

Thank you for trusting me for your health care concerns. Susan Ponder/ IMH

updated: 12.18.'19