MIND Therapy CLINIC

INNOVATIVE MEDICINE, PERSONALIZED CARE

Welcome!

We appreciate the confidence you have placed in us, and look forward to serving your psychiatric needs. We are aware you have options in pursuing psychiatric care and want you to know we are dedicated to providing the highest quality care.

With the many administrative and legal demands on the practice of medicine, our office has developed policies and procedures that enable us to continue serving our clients at the highest level of care.

Our hope is that in reading the enclosed information, you will further understand how to navigate the complicated medical world as it relates to your time in our care. Please take the time to read them carefully and should you have any questions or concerns we would be happy to take the time to talk with you at our first meeting.

Thank you in advance for your attention to the enclosed information, but most of all, for your trust and confidence in choosing Mind Therapy Clinic to provide your care. We look forward to meeting you.

Sincerely,

Your Care Team at Mind Therapy Clinic

san *francisco* 2299 Post Street, Suite 104 A, CA 941 5 corte *madera* 240 Tamal Vista Blvd, Suite 160, CA 94925 mindtherapyclinic.com
p 415 945 9870 f 415 945 9325 e info@mindtherapyclinic.com

POLICIES

Appointments
Appointments are generally scheduled for half-hour, hour, and one and a half hour time periods. This includes 20, 50, and 80 minutes of face-to-face time with a clinician, and 10 minutes in which the clinician completes charts, paperwork and phone calls. We make an effort to stay on schedule to be fair to everyone and provide the best service.

It is important for you to be on time for your appointment and to complete all paperwork at initial visits, as your appointment will still need to end on schedule. Lateness may require scheduling an additional appointment to complete necessary work.

Paperwork
Our paperwork is available online on our website: www.mindtherapyclinic.com/clients. We can also send out paperwork to you by mail or email after you schedule the initial appointment so you have time to gather all appropriate information before your first visit. The completion of these forms before you come to our office is of great importance. It is imperative that we have your clinical data and exact medication history in order for us to address your needs. By having your history completed beforehand, we are able to spend our limited time together in the most effective and efficient manner. We understand that there is a lot of information we are asking for and we appreciate your efforts to provide us with a thorough and accurate history. Incomplete paperwork may prevent us from completing the initial evaluation in one session and may require that you return again to complete the appointment. Please complete the entire package before your appointment and bring it with you.

Prescription Refills
Typically, your provider writes prescriptions for the amount of medication needed until your next scheduled appointment. Patients who require refills should request their pharmacies to send an electronic or fax request for refills to our office. Please make this request at least **five (5) business day**s prior to running out of medication. Please call for refills during regular office hours.

Cancellation Policy
We require **two (2) business days** notice on all cancellations except for medication management appointments. We require **one (1) business day** notice on medication management appointments. **One (1) week notice** must be given when cancelling ongoing enrollment in any group therapy. Cancellation request during trial period for group therapy requires **one (1) business day** notice. Any requests for leave of absence must be submitted in writing, and signed and dated **one (1) week** prior to the first date of absence. An agreement regarding this policy - late appointments, cancelled late or missed for any reason - will be signed by you. **It is our policy that the time lost by the clinician, not the reason for the cancellation, is what determines a charge.**

Insurance
Mind Therapy Clinic is a fee-for-service practice. As such, we do not contract with any insurance plans. While this may seem unusual for many, we feel that this is in the best interests of our patients. Medical care should be a partnership between a patient and a physician or other clinician. Insurance companies often try to influence and control the nature of the care provided. They frequently place unreasonable constraints on treatment options and even the amount of time that clinicians spend with patients.

PATIENT AGREEMENT

CANCELLATION POLICY

Scheduled appointment times are reserved for you. All appointments are subject to full charge, whether missed, unattended or cancelled. This charge can be avoided by giving two (2) business days' notice. In order to avoid being charged the full amount of the appointment you must call by 5 p.m. at least two (2) business days prior to the appointment day (i.e., if your appointment is anytime on Monday you must call to cancel by 5 p.m. on the prior Thursday). Medication management visits require one (1) business day's notice. Group therapy is charged on a monthly basis, and the payment for the first month is due at the time of enrollment. Cancellation request during trial period for group therapy requires **one (1) business day** notice. **One (1) weeks' advance notice is required** to cancel enrollment in any group. Any requests for leave of absence must be submitted in writing, and signed and dated **one (1) week** prior to the first date of absence. Unexcused missed group sessions are not refunded. You acknowledge that Insurance companies do not pay for cancellation fees and, and these charges are your responsibility. Repeated "no show" appointments could result in treatment ending for non-compliance.

_____
(Initial)

RETURNED CHECKS

There will be a $35.00 service charge applied to your account for all returned checks.

_____
(Initial)

DELINQUENT ACCOUNTS

Should your account become 60 days delinquent, finance charges of one and one half percent (1.5%) per month may be added to your bill. Services may be discontinued, your bill may be turned over to a collection agency and you will be responsible for payment of all legal and all other collection costs.

_____
(Initial)

LIMITS OF CONFIDENTIALITY STATEMENT

All information obtained by Mind Therapy Clinic relating to the client is strictly confidential. Except as otherwise authorized by law or with your written consent, Mind Therapy Clinic clinicians share confidential information only with the internal treatment team in order to provide integrated, comprehensive care.

_____
(Initial)

MOBILE PHONES, INSTANT MESSAGES, FAXES, EMAIL, VIDEO CHATS

Mobile phone, instant messages, video chats, and email communication may not be secure. Faxes can also be easily sent to erroneous numbers. If you are using a cell phone while communicating with our office, you must be aware that we cannot ensure the confidentiality of the call. If you use email to communicate with Mind Therapy Clinic then we will assume that you have made an informed decision that you are taking the risk of such communication being intercepted. Please do not communicate an

emergency by email or fax.

_____
(Initial)

MESSAGES

It may be necessary at times for our office to leave you a message at the phone number(s) you provide us. By supplying us with specific phone numbers, you authorize us to leave messages for you at those numbers.

_____
(Initial)

EMERGENCY ACCESS

We try to service our clients whenever possible; however we are not a 24-hour facility. In case of an emergency, call 911 or go to the nearest emergency room.

_____
(Initial)

CONSENT FOR TREATMENT

I authorize and request my practitioner to carry out psychological exams, treatment and/or diagnostic procedures, which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that I am responsible for the costs of such exams and/or diagnostic procedures. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. I understand and acknowledge that from time to time I may have a phone or video session. I authorize these sessions.

_____
(Initial)

ELECTRONIC RECORD KEEPING SYSTEM

Mind Therapy Clinic uses Electronic Medical Records (EMR) to securely maintain your health care information. Electronic Medical Record means an electronic record of health-related information that: includes my demographic and clinical health information, such as medical history and problem lists; and has the capacity: to provide clinical decision support; to support physician entry and billing invoices; to capture and query information relevant to healthcare quality; and to communicate with me through patient portal about my care. By initialing here, I understand that my healthcare information is maintained in this way.

_____
(Initial)

BILLING

Itemized billing statements are available through a secure patient portal website, and my unique access is available when I activate the online account assigned to me. If I do not create an account, it is my responsibility to request the billing statement to be mailed to me. An invoice will be placed in my secure portal for any unpaid balance. If the invoice remains unpaid for 120 days, my account will be in default and auto referred to a collection agency. The balance of any account not paid within 60 days will begin to accrue interest at the rate of 1.5% per month or the maximum allowed by applicable law, whichever is lower.

If I do not agree with the billing provided in my billing statement, I understand that I have thirty (30) days from the date of the statement to report errors or objections. If there are problems with my account, it is my responsibility to contact Mind Therapy Clinic to address the problem or to discuss a workable solution. If a workable solution cannot be reached, I agree to the arbitration process administered by the American Health Lawyers Association (AHLA) Dispute Resolution Service and conducted pursuant to the AHLA Rules of Procedure for Arbitration. Judgment on the award may be entered and enforced in any court having jurisdiction. In the event of a legal action to enforce the terms of this Agreement, including collection of amounts payable or Mind Therapy becomes party to any legal proceedings relating to my treatment at Mind Therapy Clinic, Mind Therapy Clinic shall be entitled to payment from me or my Guarantor of its reasonable attorney's fees and costs, including any collection costs.

_____
(Initial)

USE OF INFORMATION RELATED TO MY TREATMENT

I give permission to Mind Therapy Clinic and its business associates to use my information if it relates to my treatment.

_____
(Initial)

PATIENT AGREEMENT

I have been notified by Mind Therapy Clinic of my responsibility for cancellation policy/fees. I authorize release of information to my Primary Care Physician, psychotherapist, psychiatrist, other healthcare providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I authorize the release of necessary information to a collection agency should that become necessary.

_____ _____
Patient Signature or Parent/Guardian signature if patient is a minor Date

FINANCIAL AGREEMENT

This Financial Agreement (the “Agreement”) is made by and between the undersigned Client, and if applicable, Guarantor (individually or collectively the “Responsible Party”) and Mark J. Schiller PC, DBA Mind Therapy Clinic (“Mind Therapy Clinic”). Responsible Party agrees that in consideration for Client’s receiving certain treatment services as described herein, Responsible Party assumes full financial responsibility for the charges relating to such services provided to the Client.

Responsible Party shall be responsible for any amounts due for any amenities or services Client receives from Mind Therapy Clinic. These charges are due at the time of service. Mind Therapy Clinic will bill Responsible Party directly for any balances due, including, but not limited to, charges unpaid or missed appointments. If Responsible Party fails to make payment on any balances due or make satisfactory payment arrangements with Mind Therapy Clinic for any balance due, Mind Therapy Clinic may turn Client’s account over to a collection agency or take legal actions pursuant to any breach of this Agreement. Any such collection efforts may necessitate that Mind Therapy Clinic, or its designee, request financial and credit information from various sources including, without limitation, credit reporting bureaus.

Any checks returned for non-payment will automatically be charged to Client’s account including a $35 service charge.

Other than any collection action, which may be pursued by Mind Therapy Clinic before any court with jurisdiction over Client and/or Guarantor, any dispute arising out of or relating to this Agreement, Client’s treatment by Mind Therapy Clinic or the subject matter hereof, including any dispute regarding the scope of this clause, will be resolved exclusively through arbitration administered by the American Health Lawyers Association Dispute Resolution Service and conducted pursuant to the AHLA Rules of Procedure for Arbitration. Judgment on the award may be entered and enforced in any court having jurisdiction. In the event Client, Guarantor or Mind Therapy Clinic initiates any legal action to enforce the terms of this Agreement, including collection of amounts payable hereunder, or Mind Therapy Clinic becomes party to any legal proceeding relating to Client’s treatment by Mind Therapy Clinic, Mind Therapy Clinic shall be entitled to payment from Responsible Party of its reasonable attorney’s fees and costs, including any collection costs.

To the greatest extent permitted by applicable law Responsible Party (a) agrees to indemnify, defend and hold harmless Mind Therapy Clinic and its agents, officers, shareholders contractors and employees (“Released Parties”) from and against any action arising out of or related to Client’s treatment by Mind Therapy Clinic and (b) waives, releases and discharges any of the Released Parties from any liabilities associated with Client’s treatment by Mind Therapy Clinic except to the extent of the sole gross negligence of any Released Party.

Responsible Party shall be liable for any loss, damage, destruction or theft to real or personal property caused by negligence or willful acts of Client. Property damage may include harm to vehicles, furnishings, fixtures or any other possession of Mind Therapy Clinic. The amount of recovery for property damage may be established by evidence of replacement value, cost of repairs, or loss of use until repaired or replaced.

The terms and conditions of this Agreement shall be jointly and severally binding upon Guarantor,

Client, and their respective assigns, successors in interest, heirs, devisees and personal representatives. This Agreement shall inure to the benefit of the parties and their respective successors and assigns.

If any term or provision of this Agreement is determined to be invalid, illegal or unenforceable, the performance of the offending term or provision shall be excused as if it had never been incorporated into this Agreement, and the remaining part of this Agreement shall not be affected thereby and shall continue in full force and effect, and this Agreement shall be reformed to implement as nearly as practicable the intent hereof.

GUARANTOR, CLIENT AND MIND THERAPY CLINIC EACH EXPRESSLY ACKNOWLEDGE AND AGREE THAT THIS AGREEMENT, INCLUDING ALL EXHIBITS ATTACHED HERETO, IS A COMPLETE STATEMENT OF THE AGREEMENT OF THE PARTIES WITH RESPECT TO THE SUBJECT MATTER HEREOF AND SUPERSEDES ANY PRIOR OR CONTEMPORANEOUS REPRESENTATIONS. *Any agreement hereafter made shall be ineffective to modify, supplement or discharge the terms of this Agreement, in whole or in part, unless such agreement is in writing and signed by the party against whom enforcement of the modification is sought.*

By signing, this Financial Responsibility Agreement, the persons whose signatures are affixed hereto acknowledge that they, and each of them, have read and fully understand the terms and conditions set forth herein. Each person signing this Agreement does so intending to create a legally binding and enforceable contract with financial and other binding terms and obligations, and in the case of Guarantor and Client, are jointly and severally binding on each of them.

CLIENT:

Name:_____

Date: _____

GUARANTOR:

Name:_____ Relationship to Client: _____

Date: _____

MIND THERAPY CLINIC PAYMENT AGREEMENT

I acknowledge that Mind Therapy Clinic does not accept medical insurance. Therefore I choose to contract directly with Mind Therapy Clinic for psychiatric care.

I understand that I may request a receipt of services for my psychiatric care from Mind Therapy Clinic, which I may submit for reimbursement from my insurance carrier, but I further understand that my payment to Mind Therapy Clinic is not dependent upon my receiving reimbursement from my insurance carrier.

I understand that I must create an account with the medical office by submitting a credit card number prior to the scheduling of my next appointment. **I also understand that payment for all medical services is due at the time that they are rendered and will be charged to this credit card. I further understand that appointments that have not been cancelled in sufficient time (as per the Cancellation Policy) will be charged to this credit card.**

Visa/MC Number:		
Expiration: MM/YYYY	**CVV Code** (3 digits on back of card):	**Billing Zip Code:**
Name: (as it appears on the card)		
Cardholder Signature:		
Email Address:		

I hereby acknowledge that I have read, understand, and agree to this PATIENT PAYMENT AGREEMENT with Mind Therapy Clinic.	
Patient Signature:	**Date:**
Patient Name (print clearly)	
Guarantor Signature:	**Date:**
Guarantor Name: (print clearly)	

Financially responsible party must either provide a credit card to keep on file OR pay at the time of the visit. I, financially responsible party, agree to keep the credit card information current. authorize Mind Therapy Clinic to securely store my credit card information, and charge it should I have an outstanding balance in the future. I understand that I may be given a receipt of services at my request, and that I may submit for reimbursement from my insurance carrier but that reimbursement is not guaranteed by Mind Therapy Clinic nor is my responsibility to pay for services dependent upon insurance reimbursement.

REGISTRATION FORM

Today's date:	Primary Care Clinician:

PATIENT INFORMATION

Patient's last name:	First name:	Middle:	Marital status: Single / Mar / Div / Sep / Wid / Partner

Is this your legal name? ❑ Yes ❑ No	Email address:	DOB:	Age:	Sex: ❑ M ❑ F

Street address:	Mobile phone #:	Home phone #:

Address to send statement if different:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance ❑ Treatment Facility

❑ Family ❑ Friend ❑ Close to home/work ❑ Website ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(FOR USE IN MEDICATION AND TREATMENT AUTHORIZATIONS)

Please give your insurance card to the receptionist if you are using your insurance for TMS treatments.

Person responsible for bill:	Birth date: /	Address (if different):	Phone no.:

Is this person a patient here? ❑ Yes ❑ No	Email Address:

Occupation:	Employer:	Employer address:	Employer phone no.:

Is this patient covered by insurance? ❑Yes ❑No

Please indicate primary insurance:

Subscriber's name:	Subscriber's SS:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑Self ❑ Child ❑ Spouse ❑Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑Self ❑ Child ❑ Spouse ❑Other

PRIMARY CARE PHYSICIAN AND OTHER DOCTORS		
Primary MD Name:	Clinic Name:	
Street address:	City and State:	Zip Code:
Office Phone #:	Office Fax #:	

I, _____, authorize Mind Therapy Clinic to communicate with my Primary Physician (if applicable) regarding my care. _____ (Initial)

THERAPIST AND PHARMACY				
Therapist Name (If Applicable):				
Street address:	City and State:	ZIP Code:	Office Phone #:	Office Fax #:
Other MD Name (if applicable):	Other MD Contact Information:			

I, _____, authorize Mind Therapy Clinic to communicate with my Therapist (if applicable) regarding my care. _____ (Initial)

Pharmacy (REQUIRED):				
Street address:			Office Phone #:	Office Fax #:
City:	State:	ZIP Code:		

CONTACTS - IN CASE OF EMERGENCY (BOTH PARENTS MUST BE LISTED FOR MINORS)			
Emergency Contact:	Relationship to patient:	Home phone #:	Work phone #:
For minors, names and contact information of parents/guardians:			

The above information is true and complete to the best of my knowledge. In the event Mind Therapy Clinic submits claims on my behalf to my healthcare insurance provider, I authorize my insurance benefits to be paid directly to Mind Therapy Clinic. I understand that I am financially responsible for any balance that is not paid by my insurance and that Mind Therapy Clinic cannot guarantee the extent to which my care will be paid by insurance. I also authorize Mind Therapy Clinic or insurance company to release any information required to process my claims.

Patient/Guardian Signature Date

PATIENT'S RIGHTS

You have the right to:

- Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
- Have written information about fees, method of payment, number of sessions, emergency policies, and cancellation policies before beginning therapy.
- Receive respectful treatment that will be helpful to you.
- A safe environment, free from sexual, physical and emotional abuse.
- Ask questions about your therapy.
- Refuse to answer any question or disclose any information you choose not to reveal.
- Request and receive information from the therapist about your progress.
- Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
- Know if there are supervisors, consultants, students or others with whom your therapist will discuss your case.
- Refuse a particular type of treatment, or end treatment without obligation or harassment.
- Refuse electronic recording (but you may request it if you wish).
- Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and the type of treatment.
- Report unethical and illegal behavior by a therapist.
- Receive a second opinion at any time about your therapy or therapist's methods.

If you wish to file a complaint about the clinic, please prepare a written complaint and place it in the suggestion box in the group therapy room. This information is confidential and will only be viewed by the clinic supervisor. If you wish to file a complaint about a violation of the HIPAA Privacy Rule you may file your complaint online at:

https://www.hhs.gov/hipaa/filing-a-complaint/index.html

Or, mail your complaint and consent forms to:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
Email:OCRComplaint@hhs.gov
Website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Per Federal Regulation, your treatment provider is permitted to and may choose to use or disclose protected health information (information regarding your treatment at the Mind Therapy Clinic or other relevant information that may identify you) without your authorization for the purposes listed below.

Please note that the ethical standards of mental health professionals are more stringent than this Federal Regulation in many cases, and prohibit us from unnecessarily disseminating information about you. We will only do so as absolutely necessary, and will use extreme caution with any information pertaining to you or your health status.

When it is important to do so, we will only use or disclose protected health information to the extent a recipient needs to know the information (the minimum necessary), and only if we believe the recipient will not disclose that information for any other purpose and will take appropriate steps to protect that information.

By law, mental health professionals shall safeguard the confidential information obtained in the course of practice, research, teaching or any other professional duties. With some exceptions set forth below, the mental health professional shall disclose confidential information to others only with the written consent of the client.

Your authorization is required to disclose psychotherapy notes, except in cases in which we must use such information to defend ourselves in a legal action/proceedings involving you.

If necessary, protected health information may be disclosed without your authorization for the following purposes:

1. TREATMENT: provision, coordination or management of your health care and related services, such as coordinating treatment with a third party, consulting between providers, or referring you to another provider.
2. PAYMENT: obtaining reimbursement for provision of health care, such as contacting your insurance company.
3. HEALTH CARE OPERATIONS:
   (a) Conducting quality assessment and improvement activities, such as outcome evaluation;
   (b) Reviewing the competence, qualifications, or performance of health care professionals, such as evaluation of provider performance;
   (c) Conducting training programs, such as therapist supervision or training of non-health care professionals;
   (d) Accreditation, certification, licensing, or credentialing activities, such as program accreditation for training purposes;
   (e) Conducting or arranging for medical review, legal services and auditing functions, such as fraud detection programs;
   (f) Business planning and development, such as cost-management analyses;
   (g) Business management and general administrative activities, such as activities related to compliance with privacy standards.
4. LEGAL REQUIREMENTS: complying with legal requirements.
5. PUBLIC HEALTH ACTIVITIES: complying with public health activities such as controlling disease

or reporting child abuse or neglect (State law requires we report suspected child abuse to the proper authorities).

6. DOMESTIC VIOLENCE: complying with statute/regulation/the law if we believe an individual is a victim of abuse, neglect or domestic violence.

7. HEALTH OVERSIGHT ACTIVITIES: complying with requests from authority for purposes such as audits, investigations or inspections.

8. JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: responding to an order from the court or a subpoena (attorneys are required by State law to provide us with advance notice in order to allow us to file for a protective order to safeguard your information if appropriate to the situation).

9. LAW ENFORCEMENT PURPOSES: complying with legal requirements or requests such as helping to identify or locate a suspect, fugitive, material witness or missing person.

10. REGARDING DECEDENTS: disclosing to a medical examiner, coroner, or funeral director.

11. RESEARCH PURPOSES: with permission from an Institutional Review Board or privacy board.

12. AS NECESSARY TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: preventing or lessening a serious and imminent threat.

13. SPECIALIZED GOVERNMENT FUNCTIONS: including those pertaining to Armed Forces, national security and protecting the president.

14. WORKERS' COMPENSATION: complying with laws related to workers' compensation programs.

15. INCIDENTAL DISCLOSURES: While we will take reasonable steps to safeguard the privacy of your patient health information ("PHI"), certain disclosures of your PHI may occur during, or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your PHI.

In other instances, we may use or disclose PHI without written authorization but provide you with an opportunity to agree or object to the use or disclosure. This will occur when a use or disclosure to a family member, relative or close personal friend, or any other individual you identify, is important to provide these individuals with information regarding your health care, payment, location, general condition or death, or to assist in disaster relief efforts. In emergency circumstances, we may not be able to obtain your agreement or objection; in these cases we will use our professional judgment to act in your best interests.

The following is a description of the types of uses and disclosures that require authorization under 45 CFR 164.508(a)(2)-(a)(4).

(1) Any use or disclosure of psychotherapy notes, except to carry out the following treatment, payment or health care operations: (A) use by the originator of the psychotherapy notes for treatment; (B) use or disclosure by us for our own 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; or (C) use or disclosure by us to defend ourselves in a legal action or other proceeding brought by the individual; and

(2) A use or disclosure that, as more specifically described in 45 CFR 164.508(a)(3), is required to comply with an investigation regarding privacy regulation, is required by law, is required by an oversight agency with respect to the originator of the psychotherapy notes, is allowed to a coroner, medical examiner, or funeral director for purposes permitted by law, or is allowed to prevent or lessen a serious and imminent threat to health or safety of a person or the public.

(3) Any use or disclosure of protected health information for marketing, except if the communication is in the form of: (A) a face-to-face communication made by us to an individual; or (B) a promotional gift of nominal value provided by the covered entity. If the marketing involves financial remuneration to us

from a third party, the authorization must state that such remuneration is involved.

(4) Any disclosure of protected health information which is a sale of protected health information, as defined in § 164.501, which authorization must state that the disclosure will result in remuneration to us.

Other uses and disclosures will be made only with your written authorization and you may revoke such authorization as provided by § 164.508(b)(5).

Again, the ethical standards for mental health professionals are more stringent than this Federal Regulation in many cases, and prohibit us from unnecessarily disseminating information about you. We will only do so as absolutely necessary, and will use extreme caution with any information pertaining to you or your health status.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

You have the following rights:

1. The right to request restrictions on certain uses and disclosures of protected health information as provided by §164.522(a).
    a. Mind Therapy Clinic is not required to agree to the requested restriction, except in the case of a disclosure restriction under § 164.522(a)(1)(vi) related to restricting disclosures to health plans when you have paid for the services out of pocket;
2. The right to receive confidential communications of protected health information as provided by § 164.522(b), as applicable;
3. The right to inspect and copy protected health information as provided by § 164.524;
4. The right to amend protected health information as provided by § 164.526;
5. The right to receive an accounting of disclosures of protected health information as provided by § 164.528; and
6. The right to obtain a paper copy of this notice from Mind Therapy Clinic upon request.

We have the following duties:

1. **We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify you if you are affected by a breach of unsecured health information;**
2. We are required to abide by the terms of the notice currently in effect; and
3. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that we maintain. We will post the revised notice promptly.

You have the right to complain to us and/or to the Secretary of the U.S. Department of Health and Human Services. If you believe your privacy rights have been violated, you may file a complaint and submit it to our office manager. You will not be retaliated against for filing a complaint.

For further information, please contact the HIPAA Officer at 415-945-9870.

This notice is in effect as of 10/1/2014.

Acknowledgment

I/We, _____, acknowledge receiving and reading a copy of the above information, and have had the opportunity to ask whatever questions necessary for clarification.

Client_____ Date_____

If no signature is obtained, document efforts to obtain signature and reasons why the document was not signed:

HOURS OF OPERATION

Mind Therapy Clinic's clinical/business hours are **Monday-Friday 9:00 am to 6:00 pm**
For situations arising after hours and on weekends:

Marin	San Francisco
Call 911 for emergencies.	
Call Marin Crisis Center, 415 473-6666 ext 24, for psychiatric emergency services including urgent consultation.	Call SF Crisis Hotline (415) 781-0500 or 800 /273-8255
Visit the Marin Psychiatric Emergency Room on the Marin General Hospital campus at 250 Bon Air Rd in Greenbrae.	Crisis Text Line 24/7 Confidential Support: text MYLIFE to 741741
Leave a message for the primary therapist, physician or family therapist in the event you have sought help from any of the above.	Visit the SF Psychiatric Emergency Services on the SF General Hospital campus at 1001 Potrero Ave., San Francisco 94110. Phone number: 415-206-8125
For non-emergencies: Leave a message for the primary therapist, physician or family therapist who will generally respond within one business day.	Leave a message for the primary therapist, physician or family therapist in the event you have sought help from any of the above
	For non-emergencies: Leave a message for the primary therapist, physician or family therapist who will generally respond within one business day.

Medication refills are provided during regular business hours. Please request medication refills directly from your pharmacy, allowing at least **five (5)** business days before running out. Have your pharmacy send refill requests electronically or by fax to: **415 945-9325.** For refills or prescription problems contact **415 945-9870**. *Note - most pharmacies will provide a one or **two (2)** day emergency supply of most medications.

PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION FOR PRIOR AUTHORIZATION OF MEDICATION

I authorize Mark Schiller, M.D. and Mind Therapy Clinic to submit my patient information to CoverMyMeds for the purpose of assisting in managing the prior authorization or other coverage determination process for prescription drugs. This information may include but is not limited to my name, date of birth, address and contact information, my medical condition, my treatment history, including prescription medications, my health insurance information, and/or financial information. This information is considered Protected Health Information ("PHI"), and is subject to local, state and federal regulations, and the HIPAA Privacy Rule, located at 45 CFR Part 160 and Subparts A and E of Part 164.

Once my PHI is submitted to CoverMyMeds, I understand that it will be used to submit coverage determinations to my health plan, and may be shared with related physician or pharmacy staff involved in my care. I understand that my information will be used only to the extent necessary to submit coverage determinations, and will not be published to those not involved in my care. However, I acknowledge that once my PHI is disclosed to third parties, it may no longer be subject to protection under the HIPAA Privacy Rule. I can review the full privacy policy at: http://www.covermymeds.com/main/privacy_policy or by writing to: Privacy Office, CoverMyMeds LL, 2 Miranova Pl., Floor 12, Columbus, Ohio 43215 or emailing to privacy@covermymeds.com

This authorization will be effective until I notify my provider that I do not want my information to be disclosed to CoverMyMeds. I understand that I can revoke this authorization at any time, that I am not required to sign this form, and that my healthcare provider cannot condition treatment or eligibility for benefits on my execution of this authorization. I understand that I have a right to receive a copy of this form.

NAME	
SIGNATURE	
DATE	
CAREGIVER	*relationship to patient and your signing rights on behalf of patient here.*

This authorization form does not form a relationship between the patient and CoverMyMeds or its customers. This form may be modified for use by healthcare providers who wish to supplement their existing consent program to ask for specific patient approval to use the CoverMyMeds service in the course of patient care. Providers should ensure that their consent program meets all applicable local, state, and federal regulations.

ADULT INTAKE EVALUATION

Name:	Date of Birth:	Age:	Date:
Others Present:			
Marital Status: *Married/Divorced/Separated/Single/In Relationship*		How long have you been with your partner/married?	
Do you have children? ☐ Yes ☐ No		If YES, indicate how many and their ages. How many: Ages:	
Current living situation (relationship of person(s) with whom patient resides)?			
Allergies to medication: ☐ Yes ☐ No		If YES, please describe:	

REASON FOR THIS APPOINTMENT

What are the reasons you scheduled an appointment?		
How long have you had these symptoms?		
Are these symptoms related to a life situation?	☐ Yes	☐ No
If YES, please explain:		
Do these symptoms seem to come and go regularly, as in a cycle?	☐ Yes	☐ No
If YES, please describe:		

Are you currently in psychotherapy?	☐ Yes	☐ No
If YES, who is your therapist and how long have you seen him/her?		
Do you feel that your current or past psychiatric care/psychotherapy has been helpful to you?	☐ Yes	☐ No
Why or why not?		

SYMPTOMS

Do you currently, or have you in the past, experienced: (check all that apply)		
☐ Depressed mood	☐ Unable to enjoy activities	☐ Sleep pattern disturbance
☐ Loss of interest	☐ Concentration issues/forgetfulness	☐ Change in appetite
☐ Excessive guilt	☐ Feeling worthless	☐ Fatigue
☐ Decreased libido	☐ Restlessness	☐ Feeling Slowed down
☐ Racing thoughts	☐ Impulsivity	☐ Increase risky behavior
☐ Increased libido	☐ Decreased need for sleep	☐ Excessive energy
☐ Increased irritability	☐ Crying spells	☐ Excessive worry
☐ Anxiety/Panic attacks	☐ Avoidance	☐ Hallucinations
☐ Suspiciousness	☐ Feeling hopeless	☐ Enter OTHER symptoms

Have you ever had feelings or thoughts that you did not want to live?	☐ Yes	☐ No (Skip to next section)
If **YES**, please answer the following questions.		
Do you currently feel that you do not want to live?	☐ Yes	☐ No
How often do you have these thoughts?		

When was the last time you had thoughts of dying?		
Has anything happened recently to make you feel this way?		
On a scale of 1 to 10 (10 being strongest), how strong is your desire to kill yourself currently?		
Would anything make it better?	☐ Yes	☐ No
If YES, please explain:		
Have you ever thought about how you would kill yourself?	☐ Yes	☐ No
If YES, please explain:		
Is the method you would use readily available?	☐ Yes	☐ No
Have you planned a time for this?		
Is there anything that would stop you from killing yourself?	☐ Yes	☐ No
If YES, please explain:		
Have you ever tried to kill or harm yourself before?	☐ Yes	☐ No
If YES, please explain:		
Do you <u>currently</u> engage in cutting, burning or other self-harm?	☐ Yes	☐ No
If YES, please explain:		
Have you had one or more <u>severely stressful events</u> that have affected your well-being?	☐ Yes	☐ No

If YES, please explain

MEDICAL

Medications: **IMPORTANT**: Please list any prescription & non-prescription medications, vitamins, supplements or herbs; include name, dose & how often taken and see appendix for list of medications.		
List all current medication name(s):		
List the dosage and how often taken for each medication listed above:		
List all past medication(s):		
Why did you discontinue taking each medication listed above:		
Who has been prescribing your medications (please include the name and location of the prescriber)?		
Are any of your relatives on medications? ☐ Yes ☐ No	If YES, please list the medications.	Were they helpful?
Do you have any of the following medical conditions? (check all that apply):		
☐ High/Low blood pressure	☐ High cholesterol	☐ Heart disease
☐ Cancer	☐ Diabetes	☐ Liver problems
☐ Kidney problems	☐ Respiratory problems	☐ Asthma

☐ Nervous system disorder	☐ Seizures	☐ Gastrointestinal problems
☐ Blood disorder	☐ Thyroid disorder	☐ Other glandular disorder
☐ Sleep disorder	☐ Headaches/Migraines	☐ Pain disorder
☐ Other (please be specific):		

When was your most recent physical?	MM/DD/YYYY	
Did you or your doctor have any concerns about your health?	☐ Yes	☐ No
If YES, please describe:		
Did you have any blood work done (i.e., thyroid testing)?	☐ Yes	☐ No
If YES, was anything abnormal?		

Check any significant family medical illness or history:		
☐ High/Low blood pressure	☐ Asthma	☐ Thyroid disorder
☐ High cholesterol	☐ Sleep disorder	☐ Other glandular disorder
☐ Heart disease	☐ Seizures	☐ Nervous system disorder
☐ Kidney problems	☐ Pain disorder	☐ Headaches/Migraines
☐ Respiratory problems	☐ Blood disorder	☐ Gastrointestinal problems
☐ Glucose intolerance and/or diabetes	☐ Other:	

How is your appetite?		
Have you had any recent changes in weight?	☐ Yes	☐ No
If YES, please describe:		
Do you suffer from anorexia, bulimia or any other eating disorder?	☐ Yes	☐ No

If YES, please describe:		
How are you functioning sexually?	☐ Yes	☐ No
Are any of your medications causing sexual side effects?	☐ Yes	☐ No
If YES, please describe the side effects.		
Are there other medical symptoms we should know about (e.g. forgetfulness, weight changes, dry or coarse skin/hair, change in bowel habits, etc.)?		

SLEEP HABITS			
Do you have any trouble falling asleep?	☐ Yes	☐ No	
If YES, what prevents you from falling asleep?			
How is the quality of your sleep (e.g., light, deep, etc.)?			
Do you snore?	☐ Yes	☐ No	☐ Don't Know
Have you been told that you stop breathing or gasp for breath when asleep?	☐ Yes	☐ No	☐ Don't Know
Do you wake up in the middle of the night?	☐ Yes	☐ No	
If so, how often and are you able to fall back to sleep?	☐ Yes	☐ No	☐ Sometimes
Do you feel rested in the morning?	☐ Yes	☐ No	☐ Sometimes
How long have you suffered with sleep problems?			

SUBSTANCE ABUSE		
Do you use alcohol?	☐ Yes	☐ No
If YES, how many drinks per night, and how many nights per week do you drink?		
When you drink do you drink to get buzzed, drunk or black-out?		
Do you use nicotine?	☐ Yes	☐ No
If YES, how much/often?		
Do you drink caffeinated drinks?	☐ Yes	☐ No
If YES, what and how much/often?		
Do you use any recreational drugs?	☐ Yes	☐ No
If YES, please fill out this section. If NO, please skip substance use section.		

Substance of Choice	How much?	Age of first use	Last use	Reason and Consequence
Tobacco				
Alcohol				
Marijuana or K2/"spice"				
Cocaine				
Opiates (e.g. Heroin, Kratom, Morphine, Percocet, Oxycodone, Tylenol #3, Dilaudid/hydromorphone)				
Tranquilizers/sedatives (e.g. Xanax, Ativan, Klonopin, Valium)				
PCP or LSD				
Mushrooms				
Other:				

Does your use of any of alcohol or these substances play a part in the reason for your appointment today?	☐ Yes	☐ No
If YES, please explain:		
Do your family or friends voice concern?	☐ Yes	☐ No
Have you ever been treated for alcohol or substance abuse in the past?	☐ Yes	☐ No
If YES, when and what type of treatment did you receive?		
Do any genetic relatives have a history of problems with alcohol or substance abuse?	☐ Yes	☐ No
If YES, which relative(s)?		

PSYCHIATRIC HISTORY

Have you had any past psychiatric treatment or psychotherapy?	☐ Yes	☐ No
I YES, please list the names of the psychiatrists or therapists you have seen, why you were you seen, when and for how long you were treated:		
Current and Past Diagnoses:		
☐ Anxiety	☐ ADHD	☐ Bipolar Disorder
☐ Depression	☐ Eating Disorder	☐ Schizophrenia
☐ OCD	☐ Trauma-related Disorder	☐ Somatic Symptom Disorder
☐ Autism Spectrum Disorder	☐ Alcohol/ Substance Abuse Disorders	☐ Personality Disorders
☐ Learning Disorders:	☐ Other:	
Have you had any hospitalizations for a psychiatric condition?	☐ Yes	☐ No

If yes, please explain (reason, length, etc.):		
Where and when were you hospitalized?		
Is there any psychiatric history in your family?	☐ Yes	☐ No
If YES, please explain:		
Have you ever attempted suicide?	☐ Yes	☐ No
If YES, please explain (circumstance, lethality, means, plan, medical attention needed):		
Is there a family history of suicide attempts and/or completed suicide?	☐ Yes	☐ No
If YES, explain:		
Have you ever engaged in cutting, burning or other self-mutilation?	☐ Yes	☐ No
If YES, please explain:		

MEDICAL HISTORY

Head Injuries:			
Have you ever had any head injury, sports injury to the head, falls, concussions or car accidents?	☐ Yes	☐ No (Skip to the next section)	
If YES, please describe where on the head the injury occurred and at what age:			
Did you experience amnesia or lose consciousness after the injury?	☐ Yes	☐ No	☐ Don't Know
Has there been any change in mood or memory since the head trauma occurred?	☐ Yes	☐ No	
If YES, please describe the change in mood or memory.			

Were you hospitalized for the head injury?	☐ Yes	☐ No	
If YES, please provide details of the hospitalization.			
Was any type of scan performed (CAT, MRI, EEG, etc.)?	☐ Yes	☐ No	☐ Don't Know
If YES, what did it show?			
Pain:			
Do you have any problems with pain?	☐ Yes	☐ No (Skip to the next section)	
If YES, please describe:			
What is your average daily pain level, using the pain scale from 1 to 10, 10 being excruciating pain?			
How long have you been suffering with this level of pain?			
Are you being treated for this problem?	☐ Yes	☐ No	
If YES, by whom?			
Female Patients:			
Do you have regular periods?	☐ Yes	☐ No	☐ N/A
If NO, please describe:			
Are you taking contraceptives?	☐ Yes	☐ No	☐ N/A
If YES, did you notice a change in your mood when you started or stopped birth control?	☐ Yes	☐ No	
If YES, please describe:			

Have you noticed any perimenopausal/menopausal symptoms (i.e., hair falling out, dry eyes, irregular periods, irritability, vaginal dryness, etc.)?	☐ Yes	☐ No	☐ N/A
If YES, have you consulted a doctor about this?	☐ Yes	☐ No	
Did the doctor do any additional tests other than blood work, or how did the doctor treat your condition?			
Do you experience any PMS symptoms?	☐ Yes	☐ No	
If YES, please describe:			

CHILDHOOD/CULTURAL HISTORY

Please describe your <u>childhood</u>, including your parents' relationship, lifestyle, siblings and their ages, relationships, friendships, environment, any trauma, physical, emotional or sexual abuse, and birth history.			
Are there any <u>cultural or spiritual</u> factors that you would like to tell us about?			
<u>Support System:</u>			
Do you feel that you have a support system?	☐ Yes	☐ No	
Check all that apply:	☐ Family	☐ Coworkers	☐ Friends
	☐ Significant	☐ Others	

	other	

ACADEMIC/VOCATIONAL HISTORY
Please describe your educational and vocational history:

MILITARY		
Have you ever served in the military?	☐ Yes	☐ No
If YES, what branch of the military?		
What type of discharge did you receive?		

LEGAL HISTORY		
Have you ever had any legal problems including jail, prison, lawsuits, bankruptcy, DUI etc.?	☐ Yes	☐ No
If YES, please explain		
Are you presently on diversion or probation?	☐ Yes	☐ No
If YES, what are the requirements of your diversion or probation?	☐ Yes	☐ No