Our Commitment and Your Consent to Treatment / Informed Consent

Welcome to the Better Mood Clinic of South Georgia (BMC of SGA). We understand the courage as well as the challenges you have gone through in order to come in for treatment. Being here tells us you are committed to your health and desire to get better. We promise you our optimum commitment to you and your care. You can expect attention, respect, and quality care from our team of mental health and service providers. The BMC of SGA is an integrated mental health care program designed to meet your needs through a seamless system of care. Depending on your needs and the outcome of your assessment, an intervention or treatment plan will be developed with you. This plan will guide us to better serve your needs. You, your family and medical- or school-related officials when involved are the main components of this team and the treatment process.

Communication with your treatment team is essential to effective care and treatment. Please let your providers know what you or your family member(s) need at any time. Further, it is important you understand your treatment goal and the direction of your treatment. If you do not know or understand any aspect of your treatment, please do not hesitate to ask at any time. Safety and trust are key to your treatment and specifically to the relationship you will develop with your treatment provider. Understanding this therapeutic relationship takes time and effective communication to develop we do not recommend or encourage changing providers. However, if you feel uncomfortable with your provider(s) please discuss it with them and/or the office manager and a change will be considered. Additionally, a dual role is when a provider – patient relationship overlaps with another relationship that you might have with your provider outside of the clinic like in church or school. If this occurs, please discuss it with your provider and adjustments can be made.

As with any intervention or treatment program, it is imperative you understand the risks and benefits of your care. For example, a benefit of marital treatment is a healthier and more vital marriage. However, a potential risk might be that one partner decides to separate or divorce. Additionally, getting healthier might involve taking medicine, changing your employment, reducing stress in your life, or changing a lifestyle that you are not ready to change. Ultimately, the decisions to change are up to you. Your provider(s) will explain these risks and benefits to you. Please do not hesitate to ask questions regarding your concerns at any time during your treatment. We hope you decide to take the risks necessary to improve your life.

Please review the following information and **initial after each section indicating your understanding** of that section. A BMC of SGA staff member will review it with you afterwards as needed.

Clinic Hours:
Monday, Wednesday, and Thursday: 9:00 a.m. – 6:00 p.m.
Tuesday: 9:00 a.m. - 8:00 p.m.
Friday and Saturdays: 9:00 a.m. – 4:00 p.m.
Saturday appointments are only available on the 2nd and 4th Saturday of the month. **Initials:** _____

Emergencies and Risks: If you are at risk of being hurt or of hurting yourself **during** clinic hours, please call the clinic immediately and a BMC of SGA staff member will help you decide the best course of action. If your concerns are **before or after clinic hours**, then call 911 or go to the nearest emergency room. Acadia Health Care (previously known as Greenleaf Center) in Valdosta (229-247-4357) or Turning Point in Moultrie (229-985-4815) are also available for emergent care. **Initials:** _____

Types of Appointments: Appointments may be for individual, marital, family or group treatment sessions. We also offer specialized assessments when staffing is available such as: a mental health or forensic evaluation, psychological testing, a pre-surgical assessment for bariatric or gastric bypass procedures, or a court ordered substance abuse evaluation. We may also work with the Department of

Family and Children Services to provide assessment as well as doing reviews for military overseas screenings and Exceptional Family Members. We **do not** do assessments for gender reassignments nor provide letters for those medical procedures or disability assessments. Depending on your situation, lawyers, medical personnel, Veteran's Administration and/or other officials may be involved in your care and may request a letter, deposition, or court involvement. Emotional Support Animal letters will only be provided for established patients. **There is a fee for letters, review of documents, and court consultations or appearances. Thus, please let us know as soon as possible when/if any of these special situations occur so we can adjust your appointment needs and time.** **Initials:** _____

Telemental Health or Telehealth (treatment through an electronic platform) appointments are available on occasion when approved by your provider. Secure and private communication cannot be assured when using Facetime or other electronic mediums. **Doxy.me** is the only secure platform used at this clinic. You will be provided the link to Doxy.me if your Telemental health appointment is approved. When approved you will also need to confirm that you are alone in a secure and safe area to ensure confidentiality, such as being alone in an office or at home **and not in a car, a restaurant or sitting in a family room with family and/or friends.** Also, if you have not checked in and are available for your appointment, you may be considered a **No-show** and charged for the missed appointment. You will also need to be in the state of Georgia. We will review this information with you before your appointment and have you sign a Telemental health consent. **Initials:** _____

Case management: Case management is done monthly to ensure continuity of care. If you are not seen in **2 months**, we will call you to discuss your treatment intentions. If we are unable to reach you by phone, we will send you a letter. If there remains no response from you over **3 months**, we will consider your care closed. You can call back to return to your care later when ready. **Initials:** _____

Insurance and Payments: If you are using your insurance to pay for your treatment, we must verify your identity through two forms of identification (i.e., driver's license and insurance card). If indicated, we will preauthorize all treatment sessions through your insurance provider.

All payments and co-payments are due at check-in time and before seeing your provider. If a deductible applies you will be advised and expected to pay it or a portion of it **at check in time and before seeing your provider.** **Initials:** _____

Active-Duty Military:

- If you are using your **Tricare** (medical insurance) versus being seen under **Military One Source** (non-medical counseling), you will need to update your referral with the base mental health clinic before your referral runs out to ensure your continuity of care. We will remind you when your referral update is due.
- If you are being seen in the **Military One Source program**, we will remind you when your authorizations are up and discuss future treatment options if needed. **If you have 2 or more No Shows while being seen in the Military One Source Program, you will no longer be seen within this program and will need to secure a Tricare referral from the base mental health clinic to continue your care.**

Military Family Members and Retirees: **You DO NOT need a referral** from the base medical military facility. We will take care of any authorizations needed. **Initials:** _____

Medication: Bring updated medication information to each appointment. Notifying your providers of any medication changes will ensure responsive and integrated care. **Initials:** _____

Custodial/Guardianship concerns: Because there are many types of families today, we need to make sure we have the authority legally and ethically to treat you and/or your family members. Thus, if you or your children are not biologically related, but you do have legal or joint legal custody of, power of attorney of, or guardianship of the child/elder and the patient (s), we will need to review that paperwork to determine the appropriate billing and treatment interventions. **Please have this paperwork with you at the 1st scheduled appointment.** **Initials: _____**

Social Media/Networking: Requests to "friend," engage in "friendships," business contacts, blog responses or requests for a blog response within any social media sites will not be responded to by any of BMC of SGA providers or administrative staff. Also, we respectfully request you do not take or download pictures of your providers or any BMC of SGA staff by themselves or with you and place them on any social media as it can compromise your privacy and violates your provider's and staff's right to their privacy. Questions about these requests if needed will be addressed in treatment so we can preserve the integrity of the therapeutic relationship and protect everyone's confidentiality. If for some reason an internet search on you related to your therapy is needed, we will advise you. **Initials: _____**

Your Medical/Treatment Record: Your record at this clinic is **entirely electronic**. Every visit is documented **electronically**. Information discussed with you or your family during any of your treatment interventions is confidential and will not be revealed to anyone outside of the BMC of SGA without your written permission. Our record management practices are consistent with the latest Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA requirements limit the unnecessary release of personal health information and only allow the "minimum necessary" information to be disclosed. Please let us know if you have questions about your records. You have the right to know how and if your information has been disclosed. **Initials: _____**

Under some limited circumstances your protected health information may be released without your permission. These situations are:

- **Suspicion of child, spouse, or elder maltreatment**: All providers must report **all** suspected child abuse or neglect to the appropriate local authorities. Spouse or elder maltreatment may be reported to the proper authorities as well. **Initials: _____**
- **Danger to self or others**: Providers must take **all** steps necessary to protect any individual when that person represents a serious threat to the life/safety of him/herself or others. **Initials: _____**

Electronic Communication: Secure and private communication cannot be assured when using cell/smart phone/tablets or regular email technologies. Thus, we do not use email or texting as a form of communicating treatment interactions or concerns. Information regarding appointments is not HIPPA protected and may be shared. **Use of any non-secure technologies on your part to contact any BMC staff will imply consent to return messages to you via the same non-secure technology.** If you email us via our clinic email or a provider's email, please keep it brief and provide minimal personal information. We will respond with a call or address your need at your next session. It is your right to determine if communication using non-secure technologies will be permitted and under what circumstances. In the event you choose not to allow non-secure modes of communication, contact will only be made on a secure site, such as a land line phone, wire to wire fax, or mail. Also, with the knowledge that smart phones, Alexa and other devices can transmit information when not in "off" mode, we encourage you to turn off these devices during your treatment session (change your device settings to off). **Initials: _____**

Consent to Communicate/Release Information: You may have other medical providers, family members or significant others involved in your care. Our goal is to integrate your care and involve those people in your treatment at your advisement. In order to do so, we need your consent to release any of your protected health information. Please note below anyone you want us to communicate with to meet your treatment needs. If you do not want us to communicate with anyone, write **"NO ONE"** across the line below.

Name of medical provider (s)	**Phone number or address**
_____	_____
_____	_____
Name of educational or service provider (s)	**Phone number or address**
_____	_____
_____	_____
Name of Significant Other (s)	**Phone number or address**
_____	_____
_____	_____

Please let us know below how you want us to **communicate with you** and if we can leave you a message. We will be discreet/careful, providing only the information needed to call us back. If you do not want a message left, please note this in writing below as: "**NO MESSAGES**" across the line. Please note if "**NO MESSAGES**" is chosen we may not be able to reach you to confirm or change appointments. **Thus, you will be responsible for appointment confirmations and fees for missed appointments.**

Written communications: Permitted Yes / NO Address: _____

_____

Oral Communications: Permitted Yes / NO Cell: _____
Permitted Yes / NO Home: _____
Permitted Yes / NO Alternate: _____

Electronic Communications: Permitted Yes / NO E-mail: _____

If at any time there are concerns with any aspect of your care or grievances of any kind, please do not hesitate to ask to speak to the office manager.

I have **read and understand** the above policies and procedures. I understand I may change or revoke any authorizations I have given at any time. Other releases of information will require an additional authorization.

_____ _____
Patient Signature Date

_____ _____
Legal Guardian Signature and Relationship to patient Date
(Must be signed if patient is under 18)

Reviewed with signer by: _____ _____
BMC of SGA staff member Date

Name _____
Last 4: _____ DOB: _____

BETTER MOOD CLINIC OF SOUTH GEORGIA, LLC.

CHILD MENTAL HEALTH CLINICAL INTAKE

How do you want us to refer to your child, or what name or pronoun would you like us to use in referring to them_____?

Section I: Your Child's Concerns and Stressors

What reasons led you to seek help today? _____

_____

Was there a recent event that made it important to seek treatment today? ___

_____

When did these concerns start; how long have they been occurring? _____

_____

Are the concerns or symptoms constant or intermittent? _____

What has been tried in the past to solve these concerns? _____

_____

Have you sought help for these concerns/symptoms in the past? _____

Was it helpful? Yes / No, please explain_____

_____

Has your child been diagnosed with a psychological condition? Yes / No

If yes, please explain: _____

Has your child ever been hospitalized for psychological reasons? Yes / No

If yes, where and when? _____

Has your child been prescribed psychiatric medications? Yes / No

If yes, please list: _____

_____

How did these meds affect *your* child? _____

Does anyone in your family have a psychological condition? Yes / No

If yes, how are they related to your child and what is their condition: _____

_____

What are your child's present stressors: _____

_____

Has your child experienced a significant life change(s) or event(s)? Yes / No

If yes, please explain: _____

What does your child do for leisure or fun? _____

Shaded Area is for Clinicians only:

Name _____
Last 4: _____ DOB: _____

Section II: Present Emotional State/ Psychiatric /Psychological Symptoms:

Is your child having or experienced:

- Extreme or sudden depressed mood — Yes / No
- Loss of interest in pleasurable things — Yes / No
- Increased guilt or disappointment in yourself — Yes / No
- Change in energy — Yes / No
  - ✓ Has their energy level increased / decreased? _____
- Difficulty in focusing or concentrating — Yes / No
- Change in appetite — Yes / No
  - ✓ If yes, weight loss / weight gain? How much? _____
- Feelings of being run down and lethargic — Yes / No
- Change in sleep patterns — Yes / No
  - ✓ Has sleep increased / decreased & how much? _____
- Mood swings — Yes / No
- Rapid or pressured speech — Yes / No
- Feelings of being keyed up or restless — Yes / No
- Racing thoughts they can't stop — Yes / No
- Engaging in impulsive or dangerous activities — Yes / No
- Panic Attacks: If yes, how often _____ — Yes / No
- Unusual or irrational fears. If yes, please explain — Yes / No

  _____
- Repetitive thoughts (obsessions) — Yes / No
- Hearing or seeing things that others do not — Yes / No
- Beliefs that others are trying to harm/control them — Yes / No

  If yes, who? _____
- Isolating from people and wanting to isolate him/herself — Yes / No
- Traumatic event (ex., deployment, rape, abuse, hurricanes…) — Yes / No
- If yes, please describe: _____
- Unexplained Losses of time: If yes: how often? _____ — Yes / No
- Emotional numbing / Absence of feelings — Yes / No
- Flashbacks or intrusive memories — Yes / No
- Frequent nightmares, night terrors or sleepwalking — Yes / No
- Body image problems — Yes / No
- Eating uncontrollably or not much at all — Yes / No
- Chronic physical discomfort — Yes / No
- Behavioral problems: breaking things or hitting someone? — Yes / No
- If yes, what happened? Was your child arrested? _____

Name _____
Last 4: _____ DOB: _____

Section III: Social History / Early Development:

Where was your child born and raised? _____
Where does your child's extended family reside? _____
How many brothers or sisters does your child have? _____
Are there significant events in your family? (Ex. adoption, divorces, unwed, transgender parents…) Please describe:_____
Describe your current living situation? _____
Race/Ethnicity (circle all that apply): Caucasian or white American / African or African - American / Asian or Asian – American / Hispanic / British German / Italian / Filipino / Korean / Mixed / Other _____
Are you experiencing any interracial / intercultural or blended family concerns: If yes, please describe? _____

_____

Were there any complications in the birth of your child? Ex. Premature….
If yes, please describe: _____
Were there delays in developmental milestones? Ex: Walking, toilet training, feeding, speech: _____

_____

Does your child have any coordination problems? Ex. Tying shoes, riding a bike, jump rope, writing their name, etc: _____
Does your child tend to play alone or have difficulties with peers? _____

_____

Does your child resist being held or touched? _____
Does your child engage in eye contact / reciprocal communication? _____
Does your child sleep with another family member? _____
Does your child have any unusual bonds to foods, toys, objects? _____
Does your child have difficulty with change? _____
What grade is your child in? _____
What were their recent qtr/semester grades? _____
What school does your child attend? _____
Is your child in any special education or gifted classes? _____
Does your child belong to any groups, churches or organizations? If yes, please list: _____
Do you have any cultural/religious beliefs that shape your child's life (for better or worse) If yes, please describe? _____

Section IV: Self - Stimulation / Self - Harm:

Does your child engage in self-stimulation? Yes / No
If yes, what kind of behavior? _____
Has your child ever cut, hit or burned him/herself on purpose? Yes / No
Has your child expressed a desire not to be alive? Yes / No
Has your child expressed thoughts to hurt him/her self or another? Yes / No
If yes to any of the above, please describe: _____
Are you afraid to leave your child alone? _____
Is your child having any of these thoughts right now? Yes / No
If yes, please explain. _____

Do they currently have a weapon and what is it? _____ Yes / No

Section V: Substance Abuse / Repetitive Behaviors:

Does your child use tobacco? Yes / No

- If yes, how many packs/cartons per day? _____

Does your child drink alcohol? If yes, answer the following questions?

- How much and how often? _____
- Have they experienced blackouts or have passed out? Yes / No

Have they tried to or wanted to stop smoking or drinking? Yes / No
If yes, what happened? _____

Does your child use marijuana, heroin, crack, cocaine or other street drugs?
If yes, please explain: _____
Do they misuse Oxycontin, Lortab, Vicadin or other prescribed medications?
If yes, please explain: _____

Has your child ever watched pornography? Yes / No
How much time does your child spend on the internet, Facebook, follow
Twitter or play computer games in a given week? _____
Have they ever received treatment for any of the above behaviors? Yes / No
If yes, where and when? _____

Section VI: Child Strengths:

Please elaborate on your child's strengths: _____
_____
_____

Name _____
Last 4: _____ DOB: _____

Section VII: Legal / Medical:

Is anyone in the family experiencing any legal problems? Yes / No
If yes, please describe: _____
Have/ Is your family involved with the Department of Family and Children Services? If yes, please explain: _____

How would you describe your child's health? Poor / Good / Very Good
Are there any height or weight concerns: If yes, please describe _____
Are there any vision, hearing or eating problems? _____
Does your child have any food or medication allergies? _____
Does your child have any chronic or serious illnesses? _____
Does your child have a disability? If yes, please describe: _____
Does your child have a history of a head injury? _____
Has your child had any recent hospitalizations or surgeries? _____

Is your child experiencing gender identity or gender expression concerns?
If yes? Please explain: _____
Has your child gone through puberty? Yes / No
To the best of your knowledge is your child sexually active? Yes / No

Are there other problems not listed here that are affecting your child's ability to function? _____
_____

Treatment Goals (Please circle those that apply to your child):

Improve behaviors / manage anger better
Improve family relationships
Improve concentration and ability to focus
Reduce sadness / depression
Reduce nervousness / anxiety
Reduce stress / racing thoughts
Stop recurrent / ongoing thoughts or behaviors
Stop addictive behaviors
Other:

Signature of Patient/ Guardian:
Date:

BMC of SGA Provider:
Date:

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

Informed Consent for Telemental Health Treatment

Telemental Health (teletherapy) is a broad term referring to the provision of mental health and substance abuse services from a distance through an electronic platform. The Telemental Health services provided at the Better Mood Clinic of South GA (BMC of SGA) use the Doxy.me platform. The platform uses two-way, interactive videoconferencing as the modality by which telemental health services are provided. The process occurs in ***real time***, meaning there are minimum delays in speech, interactions, or processes. Initially this new process may be a little awkward for you, but we hope in time the computer screen will become transparent to you and it will feel like your provider is with you in the office. Teletherapy, however, is neither a universal substitute, nor the same as face-to-face psychotherapy. Therefore, your treatment provider will need to approve the service.

There are risks and consequences from teletherapy. Despite the best efforts of any Telehealth platform to ensure high encryption and secure technology, the following could occur. The transmission of information could be disrupted or distorted by technical failures; the transmission of information could be interrupted by unauthorized persons; and/or the electronic storage of medical information could be accessed by unauthorized persons. If anything did occur, we would advise you and manage the situation as indicated with our lawyers.

Types of Telemental Health are between mental health providers in consultation, between a provider and another health care provider (e.g., case manager, clinical nurse practitioner or physician assistant), or between mental health professionals and a patient. Other persons, such as another health care provider or family member, may also be present in a session. As the patient or patient's representative, you have the right to request inclusion or the exclusion of any additional individual from your treatment process.

The same fee rates apply for teletherapy as they do for in-person psychotherapy. However, some insurance or managed care providers may not cover sessions that are conducted via telecommunication. We will ensure prior to engaging in teletherapy sessions that your insurance company will cover teletherapy if it is offered to you. If your insurance, or other managed care provider does not cover electronic psychotherapy sessions, you will you have the option to pay out of pocket. **All private pay and Copays will be collected <u>prior</u> to services rendered.**

During your Telemental Health session your provider will assess, diagnose, and treat you as they would if you were in the office with a few exceptions requiring hands-on practices. You will be provided with the link to Doxy.me if your Telemental health appointment is approved. When approved you will be educated on the process and the expectations.

For example, each session we will need to confirm that you are alone in a secure and safe area to ensure confidentiality, such as being alone in an office or at home **and not in a car, a restaurant or sitting in a family room with family and/or friends.** Also, you will not be allowed to drive while having a Telemental health session. You will be asked to pull over to a safe and secure location. You

will need to be appropriately dressed for the session. If you are not, your provider will discuss the concern with you. If you have not checked in and are available for your appointment, you may be considered a **No-show** and charged for the missed appointment. You will also need to be in a state in which your provider is licensed or there is a license compact agreement with the state you are in.

There is some leeway given to these limitations if you are in the military and on orders on a secure military installation. We will review this information with you before your appointment and have you sign a Telemental health consent. As always, if you have any questions, please do not hesitate to ask.

As always if concerns occur after hours, call the ER at South Georgia Medical Center (229) 433-1000 or Greenleaf Center at (299) 588-8215. If there is an emergency, please call 911.

We are thrilled to be able to offer you this service and are grateful you are entrusting us to continue to serve you. As always, feel free to ask any further questions of the BMC of SGA staff you may have regarding this treatment process.

Please sign below indicating your understanding and consent to Telemental Health Services.

_____ _____

Patient Signature Date

If the patient is a minor, we require the child's guardian or parent to sign noting their representation and understanding of the Telemental Health process. Thank you!

_____

Parent or guardian

CUSTOMS AND COURTESIES AGREEMENT

The Better Mood Clinic of South Georgia, LLC is a therapeutic environment. Your appointment is just for you! Please help us provide you the best possible services by observing the following guidelines:

- **No Food allowed in the lobby**
- Keep our surroundings serene by keeping noise levels down
- **There are times you might recognize someone in the lobby you work with, supervise, go to church with or know. In the event this situation occurs, and you are uncomfortable, please let staff know so we can offer you another place to wait.**
- Cell phones are great devices, however, here they have become vices.
    - For privacy and good manners, leave them in your car or silence them
    - If on call or if a true emergency occurs, put them on vibrate
    - **Do not** talk on the phone in the lobby as it will disturb others waiting for their session.
- Bring only essential people to your treatment sessions
    - Patient, parents or caregivers if patient is a minor or ward of the state
- **No children can be left in the waiting area**. Please arrange childcare
- Be on time and check in upon arrival
    - Advise our staff if you are waiting more than 15 minutes
- Emergencies occur here; we appreciate your tolerance if your appointment is delayed
    - You too will receive the extra time and TLC if you are having a crisis
- Payment and co-pays are due at the time of service
    - Balances are due within one month of service
- A **$60 fee** is charged for each no-show or cancellation with less than 24 hours' notice
    - We do not double book appointments; your time is allocated **just for you.**
- HIPAA requires that we protect **all** your medical and health information
    - Only those **you** identify in your **Consent to Treatment** will be given any information on your care

Thank you for helping us with our goal to provide a positive experience. With your assistance, we can help you achieve a **Better Mood.** We appreciate the opportunity to serve you.

By signing below, I acknowledge that I have **read, understand and agree** to the Customs and Courtesies Agreement. I acknowledge that a record of this agreement can be emailed or printed out for me, if requested, for my records.

_____ _____

Patient Name Date

_____

Signature (If patient is a minor, legal guardian must sign)

_____ _____

BMC Staff Member Date

Better Mood Clinic
of South Georgia, LLC
2935 N. Ashley, Bldg F
Valdosta, GA 31602
Ph (229) 333-2273; Fax (229) 506-5403

Patient Financial Agreement

Thank you for choosing the Better Mood Clinic of South Georgia as your mental health provider! Our goal is to provide you with the services you need to feel better and become healthier and happier. An important aspect of optimal patient care is to have an agreement regarding your financial responsibility with us to avoid any misunderstandings and ensure timely payment for the services you received.

Better Mood Clinic of South Georgia requires that all patients, or their legal guardian, sign the Consent to Treatment and Financial Agreement prior to services being rendered. The Consent to Treatment authorizes Better Mood Clinic of South Georgia to render services to the specified patient(s). The Patient Financial Agreement advises patients of their complete financial responsibility for all services rendered.

It is our expectation that you will **keep your account current.** If there are problems that interfere with you keeping your account current, please ask to speak to our account's manager as soon as possible. Please note: **All** fees are due at the time of your service.

Initials: _____

Insurance:

This office files insurance claims at no additional charge to the patient/guardian. **However,** insurance information must be provided and verified before an appointment can be scheduled.

By signing this agreement, I allow Better Mood Clinic of South Georgia to bill my insurance on my behalf.

NEW CARD ON FILE FEATURE

As with many medical/dental, car rentals and hotels, the first thing you are asked for is a credit card, which is scanned and later used to pay your bill. This is an advantage for both you and the company, as it makes the checkout process easier, faster, and more efficient.

We have now implemented this policy at the Better Mood Clinic of South Georgia. Thus, you will be asked for a credit card at your first check in, we will scan the card in our system, and the information will be held securely.

Should your account collect a balance, you will be sent two statements. The second statement will contain a letter advising you that, should you not contact our office or remit payment within 30 days, we will charge the balance to the card on file.

Initials: _____

Forms of Payment Accepted:

Check * Cash * Money Order * HSA * Visa * Master Card * American Express * Discover

You will be asked to pay for the cost of any returned checks and all additional business costs related to the outcome of your financial situation. Minimally, these fees are $35. If your check is returned, you will not be able to write checks to this clinic until you can verify the availability of funds. If your card is declined, you will be asked for another form of payment. Treatment will resume when your account is current with no unpaid fees.

Be advised that all Credit/Debit Card transactions will incur a convenience fee of $2.50. If you are paying any amount over $100 there will be a convenience fee of $5.00.

Initials: _____

Late Arrivals, Late Cancelations, & No Shows:

Late Arrivals – Patients arriving more than 15 mins late for their appointment will have a shortened session or be asked to reschedule. If rescheduled, you may be charged a no-show fee. We understand situations occur, so be respectful and advise us when running late.

Late Cancelations – Any appointment canceled less than 24 hours before their appointment time will be charged a fee based on the appointment type.

No Shows – Any time a patient does not show for an appointment they will automatically be charged a corresponding fee. That patient will not be able to schedule another appointment until the fee has been paid.

A "DNS" or Missed appointments are not only a loss of revenue but it also denies others from receiving treatment.

Initials: _____

Fees for Services:

Service Type	Therapist	Psychologist
Initial Visit	$185.00	$220.00
Follow Up Visit	$150.00	$170.00
Group Therapy	$75.00	
Psych Testing		$250.00 per session

Late Cancelation/No Show Fees

	Therapist	Psychologist
Follow Up Visit	$60.00 per hour	$80.00 per hour
Psych Testing		TBD

Initials: _____

Preferred Mailing Method to Receive Your Statement:

____ Mail
Address: _____

_____

____ Email
Email Address: _____

Initials: _____

By signing below, I acknowledge that I have **read, understand and agree** to the Patient Financial Agreement. I acknowledge that a record of this agreement can be emailed or printed out for me, if requested, for my records.

_____
Patient Name

_____ _____
Signature (If patient is a minor, must be signed by legal guardian) Date

_____ _____
BMC Staff Member Date