Our Commitment and Your Consent to Treatment

Welcome to the Better Mood Clinic of South Georgia (BMC of SGA). 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 are the main components of this team and its 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 don't hesitate to ask at any time.

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 aren't ready to change. Your provider(s) will explain these risks and benefits to you. 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: 9:00 a.m. – 6:00 p.m., Monday, Wednesday and Thursday; 9:00 a.m. - 8:00 p.m. Tuesday; 9:00 a.m. – 4:00 p.m. on Friday and the 2nd and 4th Saturdays of the month. **Initials: _____**

Emergencies and Risks: If you are at risk to be hurt or to hurt 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. Arcadia 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 individual, marital, family or group. There are also specialized medical assessments such as: a mental health or forensic evaluation, a disability assessment, psychological testing, a pre-surgical assessment for bariatric or gastric bypass procedures, or a court ordered substance abuse evaluation. Lastly, there may also be a Department of Family and Children Services assessment, or a military overseas screening. Depending on your situation, lawyers and other officials may be involved in your care and may require a letter, deposition or court involvement. Please let us know as soon as possible when/if any of these special situations occur so we can adjust your appointment **needs, times and fees.** **Initials: _____**

Late, Missed or Same Day Cancellations: If you know you will be late (greater than 10 minutes) or you will miss an appointment, please call as soon as possible to reschedule your appointment. **Failure to show for an appointment or failure to cancel an appointment within 24 hrs of your appointment will cost you $50**. This fee may be waived by your provider only. Missed appointments are not only a loss of revenue to your provider but they deny others from receiving their treatment. **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. Additionally, we have preauthorized your initial appointment and will preauthorize all treatment sessions through your insurance provider and will also file your insurance claims.

If you do not have insurance or you are choosing not to use your insurance to pay for these services, or if you are using your insurance, **all fees, payments or copayments 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, you will need to update your referral with the mental health clinic on base 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 under Military One Source, we will remind you when your authorizations are up and discuss future treatment options.

  Initials: _____

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 meet with our office manager as soon as possible. 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 problems. **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 possibly 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 possibly 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: _____**

Your Medical/Treatment Record: Every visit is documented electronically in your clinical record at the BMC of SGA. 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 from harm when a person represents a serious threat to the life/safety of him/herself or others. **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. Questions about these requests will be addressed in treatment so we can preserve the integrity of the therapeutic relationship and protect everyone's confidentiality. If for some reason we need to do an internet search on you related to your therapy, we will advise you. **Initials: _____**

Consent to Communicate/Release Information: Many of 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 needs. If you do not want us to communicate with anyone, write **"NO ONE"** across the line.

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**
_____	_____
_____	_____

Secure and private communication cannot be fully assured when using cell/smart phone or regular email technologies. It is your right to determine if communication using non-secure technologies will be permitted and under what circumstances. **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, pending further clarification from you.

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.

Please let us know how you want us to **communicate with you** and if we can leave you a message. We will be discrete/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: _____
Permitted Yes / NO Texting: _____

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