Cornerstone Mental Healthcare, PLLC/ Cornerstone Mental Healthcare Ohio, LLC

Phone: 513-790-4792 Fax: 970-585-8304

CONSENT FOR TREATMENT AND POLICIES

Client Name:_____
Date/Time:_____

1. Cornerstone Mental Healthcare, PLLC/ Cornerstone Mental Healthcare Ohio, LLC ("CMH") is a telehealth agency services the states of Colorado and Ohio.

2. The primary provider at CMH is Krishawnda Scott, MSN, APN-RXN, PMHNP-BC. She earned her Master's of Science in Nursing from Eastern Kentucky University.

3. Krishawnda provides medication evaluation and management for those coping with mental disorders. Although you may receive some psychotherapeutic benefit from your work with her, the services you receive at CMH are not considered psychotherapy. Should your provider believe you would benefit from work with a provider she will provide you with treatment option referrals.

4. Everyone fifteen (15) years and older must sign this disclosure statement. A parent or legal guardian with the authority to consent to mental health services for their minor child/ren, must sign this disclosure statement on behalf of their minor child under the age of fifteen (15) years old. This disclosure statement contains the policies and procedures of CMH and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Colorado law, Ohio law, and Federal Regulations (42 C.F.R. Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 142, 160, 162 and 164).

PATIENT RIGHTS AND IMPORTANT INFORMATION: Fees: 1. CMH fee structure, services, and fee policy provided are outlined as follows:

Ohio Fees: fee structure is based off personal insurance company and Headway, mental health provider and billing agency

Colorado Fees:
Initial Evaluation - 60 minutes: $250.00
Medication Management or Follow-up - 25 minutes: $125.00
Medication Management or Follow-up - 50 minutes: $250.00
Prescriptions written between appointments - $20.00
Letters or other documentation requiring signature of provider (if under 10 minutes needed): $30.00

Failure to make your appointment or appointments canceled within 24 hours of the appointment time may be charged the full appointment fee.

Phone calls, collateral contact, administrative or other client-related time over 10 minutes will be prorated based on $225.00 per hour fee (aprox. $3.75 per minute), including the first 10 minutes of the call. Calls under 10 minutes will not be billed provided they are not excessive in frequency.

Payment is due at time of service. A $20 billing fee will be incurred for any payment not made at the time of service, and an additional $20 fee will be incurred for any payment over 30 days past due

After hours or crisis management, when required, will be billed for in full, including but not limited to, phone calls, collateral contact and note writing. We are a by appointment only provider so any services outside a scheduled appointment may be billed at double my hourly rate ($450.00 per hour).

Any court testimony is charged at a higher rate including but not limited to: testimony related matters like case research, case review, report writing, travel, depositions, actual testimony, cross examination time, courtroom waiting time, and attorney fees your provider may incur in preparing for the requested legal services. This higher rate is charged for all legal related work even if no case is filed. The higher rate is $450 per hour for the above court related matters. In addition, a $900.00 deposit is required prior to commencing work.

It is the policy of CMH to collect all fees at the time of service, unless you make arrangements for payment and we both agree to such an arrangement. In addition, we request that you fill out a "Credit Card Authorization" form to keep in your file. All accounts that are not paid within thirty (30) days from the date of service shall be considered past due. If your account is past due, please be advised that we may be obligated to turn past due accounts over to a collection agency or seek collection with a civil court action. By signing below, you agree that we may seek payment for your unpaid bill(s) with the assistance of a collections agency. Should this occur, we will provide the collection agency or Court with your Name, Address, Phone Number, and any other directory information, including dates of service or any other information requested by the collection agency or Court deemed necessary to collect the past due account. We will not disclose more information than necessary to collect the past due account. We will notify you of my intention to turn your account over to a collection agency or the Court by sending such notice to your last known address.

Ohio clients: We are not a Medicaid provider. If you have Medicaid coverage that includes mental health medication evaluation and/or medication management, we are not able to offer mental health services to you.

Legal Services incurred on your behalf are charged at a higher rate including but not limited to: attorney fees we may incur in preparing for or complying with the requested legal services, testimony related matters like case research, report writing, travel, depositions, actual testimony,

cross examination time, and courtroom waiting time. The higher fee is $450.00/hour. A $900.00 deposit is required prior to commencing work.

Restrictions on Uses: 2. You are entitled to request restrictions on certain uses and disclosures of protected health information as provided by 45 CFR 164.522(a), however CMH is not required to agree to a restriction request. Please review CMH's Notice of Privacy Policies for more information.

Second Opinion and Termination: 3. You are entitled to seek a second opinion from another provider or terminate services at any time.

Confidentiality: 4. Generally speaking, the information provided by and to a Patient during an appointment is legally confidential if the provider is Registered Nurse or Licensed Practical Nurse. If the information is legally confidential, the provider cannot be forced to disclose the information without the Patient's consent or in any court of competent jurisdiction in the State of Colorado or Ohio without the consent of the person to whom the testimony sought relates.

5. There are exceptions to this general rule of legal confidentiality. You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in C.R.S 13-90-107. There are additional exceptions that we will identify to you as the situations arise during treatment or in our professional relationship. For example, We are required to report child abuse or neglect situations; We are required to report the abuse or exploitation of an at-risk elder or the imminent risk of abuse or exploitation; if we determine that you are a danger to yourself or others, including those identifiable by their association with a specific location or entity, We are required to disclose such information to the appropriate authorities or to warn the party, location, or entity you have threatened; if you become gravely disabled, We are required to report this to the appropriate authorities. We may also disclose confidential information in the investigation of a complaint or civil suit filed against me, or if we are ordered by a court of competent jurisdiction to disclose such information. You should also be aware that if you should communicate any information involving a threat to yourself or to others, we may be required to take immediate action to protect you or others from harm. In addition, there may be other exceptions to confidentiality as provided by HIPAA regulations and other Federal and/or Colorado or Ohio laws and regulations that may apply.

Additionally, although confidentiality extends to communications by text, email, telephone, and/or other electronic means, we cannot guarantee that those communications will be kept confidential and/or that a third- party may not access our communications. Even though we may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by a third-party. Please review and fill out CMH's Consent for Communication of Protected Health Information by Unsecure Transmissions.

Termination

6. There are special instances in which CMH may decide to stop working with you, even if you wish to continue treatment. These include, but are not limited to: a failure to meet the terms of our fee agreement; a need for special services outside the areas of competency of your provider; prolonged failure to make progress with the agreed upon treatment approach; or if you are not following the treatment plan.

Electronic Records:

7. CMH may keep and store Patient information electronically on CMH's laptop or desktop computers, and/or some mobile devices. In order to maintain security and protect this information, CMH may employ the use of firewalls, antivirus software, changing passwords regularly, and encryption methods to protect computers and/or mobile devices from unauthorized access. CMH may also remotely wipe out data on mobile devices if the mobile device is lost, stolen, or damaged.

CMH may use electronic backup systems such as external hard drives, thumb drives, or similar methods. If such backup methods are used, reasonable precautions will be taken to ensure the security of this equipment and it will be locked up for storage. CMH uses Practice Fusion, a cloud-based service for storing and backing up patient information. Practice Fusion is encrypted and HIPAA compliant. The email service provider used by CMH is G-Suite. CMH may maintain the security of the electronically stored information through encryption and passwords. In addition, in order to maintain security of the electronically stored information CMH has employed the following security measures:

Entered into a HIPAA Business Associates Agreement with the cloud-based company and email service provider. Because of this Agreement, the cloud-based company and email service provider are obligated by federal law to protect the electronically stored information from unauthorized use or disclosure.

The computers that store the electronically stored information are kept in secure data centers, where various security measures are used to maintain the protection of the computers from physical access by unauthorized persons.

The cloud-based company and email service provider employ various security measures to maintain the protection of these backups from unauthorized use or disclosure.

It may be necessary for other individuals to have access to the electronically stored information, such as the cloud-based company or email service provider's workforce members, in order to maintain the system itself. Federal law protecting the electronically stored information extends to these workforce members. If you have any questions about the security measures CMH please ask.

Availability and Response Policy:

8. My normal business hours are from 8:00am to 5:00pm Monday through Friday. However, as Therapists, the majority of our business hours are devoted to seeing my clients in therapy, which

means we are not always available for immediate contact via phone, text, or email. This is especially true for emergencies, as we are not equipped to respond immediately.

The best way to contact us is via (phone/email). Every effort will be made to respond to you in a clear and timely manner. Voicemails and texts sent to 513-790-4792 will be returned within 24 hours, excluding Saturdays, Sundays, and holidays. Emails sent to krishawnda@owensporter.com will be returned within 24 hours, excluding Saturdays, Sundays, and holidays. It is our policy to return all phone calls, texts, and emails during my normal business hours (referenced above). We also reserve the right, at our sole discretion, to return communication outside of these hours; but any communication which is initiated outside of normal business hours is in no way a guarantee or a promise of availability outside of normal business hours.

AS A PATIENT: You as a Patient agree and understand the following:

1. I understand that CMH may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me in accordance with CMH Consent for Communication of Protected Health Information by Unsecure Transmissions.

2. I understand that if I initiate communication via electronic means that I have not specifically consented to in CMH Consent for Communication of Protected Health Information by Unsecure Transmissions, I will need to amend the consent form so that my provider may communicate with me via this method.

3. I understand that there may be times when my provider may need to consult with a colleague or another professional, such as an attorney or physician, about issues raised by me in treatment. My confidentiality is still protected during consultation by my provider and the professional consulted. Only the minimum amount of information necessary to consult will be disclosed. Signing this disclosure statement gives my provider permission to consult as needed to provide professional services to me as a patient. I understand that I will need to sign a separate Authorization for Release of Information for any discussion or disclosure of my protected health information to another professional besides an attorney retained by my provider.

4. I understand that I am legally responsible for payment for the services I receive at CMH. If for any reason, my insurance company, HMO, third-party payer, etc. does not compensate my provider, I understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my provider to communicate with my insurance company, HMO, third-party payer, collections agency or anyone connected to my therapy funding source regarding payment. I understand that my insurance company may request information from my provider about the services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my provider's entire Patient file. I understand that once my insurance company receives the information I or my provider has no control of the security measures the insurance company

takes or whether the insurance company shares the required information. I understand that I may request from my provider a copy of any report CMH submits to my insurance company on my behalf. Failure to pay will be a cause for termination of therapy services.

5. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado or Ohio law as described in this form and the Notice of Privacy Policies of CMH. By signing this form, I agree and acknowledge I have received a copy of the Notice or declined a copy at this time. I understand that I may request a copy of the Notice at any time.

6. I understand that should I cancel within 24 hours of my appointment or fail to show up for my scheduled appointment without notice ("no-show"), excluding emergency situations, my provider has a right to charge my credit card on file, or my account, for the full amount of my session.

7. I also affirm, by signing this form, I am at least fifteen (15) years old and consent to services here at CMH or that I am the legal guardian and/or custodial parent with the legal right to consent to treatment for any minor child/ren who is under the age of fifteen (15), for whom I am requesting services here at CMH.

8. By signing this form, I affirm that I am fully informed of the services I am requesting and that CMH is providing, and grant my consent to receive such services.

My signature below affirms that the preceding information has been provided to me in writing by my primary provider, or if I am unable to read or have no written language, an oral explanation accompanied the written copy. I understand my rights as a Patient and should I have any questions, I will ask my provider.

Patient Signature_____

2. Date:_____

3. Parent/Legal Guardian Signature _____
(Please specify Relationship to Patient)

4. Date:_____