ADVANCED PAIN CARE

INFORMATION, CONSENT AND AGREEMENT FOR TELE-THERAPY SERVICES

Name: _____ **Date of Birth:** _____

TELE-THERAPY EXPECTATIONS:

I understand that, in general, the goal of counseling is to help me learn to cope independently with my chronic pain and the demands of life and that, depending on the needs of the individual, the length of counseling varies. I am aware certain effects are possible when engaging in the counseling process—such as increased stress, emotional discomfort and the disruption of current interpersonal and family relationships. I have the right to terminate counseling at any time for any reason and understand that referrals to other providers will be provided by the therapist upon request. **It is strongly recommended that any decision to terminate counseling or to switch to another provider be discussed with the therapist.** I hereby consent to engage in tele-therapy services. I understand that tele-therapy includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that tele-therapy also involves the communication of my medical/mental information, both orally and visually. I understand that I have the following rights with respect to tele-therapy: The laws that protect the confidentiality of my medical information also protect tele-therapy, including, but not limited to, the possibility, that the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons despite using software that is HIPAA compliant. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services.

THERAPEUTIC RELATIONSHIP:

The relationship between therapist and client is the container through which client change can take place. As such, it is often one in which close emotional bonds develop. It is also a professional relationship, in which appropriate boundaries must be maintained. For the most part, the therapeutic relationship begins and ends at the therapy office. Although this is sometimes difficult to understand, it is a necessary requirement for maintenance of the therapeutic environment. As such, your therapist cannot be expected to be involved in a social relationship or friendship of any kind that exists outside of the therapy room.

THERAPIST ORIENTATION AND CREDENTIALS:

There are many different approaches to the therapeutic process. Your therapist will work with you to provide you with the most appropriate interventions for your particular issue(s) and goals. Our therapists use a variety of therapeutic modalities, including but not excluding, EMDR, hypnosis, ACT, and CBT. Please discuss any concerns you have regarding your treatment with your therapist at any time during the process. All of the therapists go through a rigorous screening process. We are committed to selecting the most qualified therapists.

CLIENT RESPONSIBILITY:

I understand that my counseling session is reserved exclusively for me, and this Agreement represents a commitment on my part to take an active role in my therapy. Therefore, I agree to the following:

- **Appointments**
  - Each therapy session will be **20-60** minutes in length. Different appointment types will be discussed with you.
- **Fee/Payment**
  - Payment is due at the time of service
  - If payment cannot be made for the current appointment, arrangements must be made for payment to occur by the end of the following appointment.
  - If payment for the current appointment is not made by the end of the day of the following appointment, sessions may be suspended until payment is made.
  - If more than one session has been without payment, termination or suspension of services may result.

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- **Punctuality**
  - I will arrive promptly at the scheduled time.
  - In the event I know I will be late for an appointment, I will notify APC's Behavioral Health Services.
  - If I am late for an appointment, I agree that the session will end at the regularly scheduled time.
  - If the therapist is late, I will be provided the full session.
- **Missed Appointments**
  - If I am unable to keep a scheduled appointment, I will notify APC's Behavioral Health Services **24 hours** in advance (512.244.4272)

CONFIDENTIALITY: APC is a multidisciplinary practice. BH providers have full access to your medical records, and the medical staff has full access to the BH records. Nevertheless, if you have a history of substance abuse disorder, that information will not be included in your medical records without additional consent. The therapist will follow all applicable laws, rules, regulations, guidelines and codes of ethics and conduct concerning your privacy relating to the therapist and the client/therapist relationship in connection with counseling sessions and records. You should be aware, however, that there are exceptions to your expectation of privacy with regard to the counseling sessions and records of those sessions with the therapist. Those exceptions include certain situations where the therapist may be obligated to disclose such information, including instances:

- Involving abuse or neglect of minors or risk to minors
- Involving abuse, neglect, or exploitation of elderly or disabled persons
- Involving abuse, neglect, or illegal, unprofessional, or unethical conduct in an inpatient mental health facility, a chemical dependency treatment facility, or hospital providing comprehensive medical rehabilitation services
- Involving sexual exploitation by mental health services provider or clergy person
- Involving abuse or neglect in nursing facility
- When the client presents a danger to self or others
- Involving certain audits of APC Behavioral Health Services or its program
- Involving a therapist's or other mental health services provider's improper conduct

Worker's Compensation – If there is a worker compensation claim, your insurance has access to your records relating to your diagnosis and treatment of the work related injury.

There may be other situations when APC's Behavioral Health Services or therapist may disclose such information without a court order, subpoena or your consent. By signing below, you acknowledge that you understand that your expectation of privacy is limited and that client/therapist communications and therapist records may be disclosed to third parties. You also agree that information regarding billing may be shared with a third party (such as insurance billing administrators and bill collectors) and that your case may be discussed with a program supervisor or treatments team, including the referring and/or treating physician. Advanced Pain Care's Behavioral Health Services uses a team approach to therapy and information is shared among staff therapist and the supervisor as appropriate to ensure professional quality. However, confidentiality standards are observed by the entire APC's Behavioral Health Services staff.

AFTER HOURS PROCEDURES

If you need to contact your therapist outside of the therapy session, you may do so by leaving a message for him or her through the Advanced Pain Care main number at 512-244-4272 (Austin locations), 806-350-7918 (Amarillo locations), or 254-741-6641 (Waco/Killeen locations). IF YOU ARE IN A CRISIS, PLEASE CALL THE 24-HOUR HOTLINE AT 512.472.HELP or 911. If you are outside of the Travis County area, you can also call 988 (National Suicide Prevention Lifeline) or contact the Crisis Text Line by texting HOME to 741741. We are not a crisis facility.

ADVANCED PAIN CARE

Name: _____ **Date of Birth:** _____

GRIEVANCE PROCEDURE OR COMPLAINTS AGAINST A THERAPIST:

The therapist will provide services in a professional manner consistent with all applicable laws, rules, regulations, guidelines and codes of ethics and conduct concerning the therapist and the client/therapist relationship. Any dissatisfaction with services or other complaint should be discussed with the therapist or the therapist supervisor. If you do not believe, your complaint was handled in a satisfactory manner, please contact:

Texas Behavioral Health Executive Council (BHEC)
Attn: Enforcement Division
1801 Congress Ave. Ste 7.300
Austin, Texas 78701
Enforcement@bhec.texas.gov

The relationship between the therapist and the client is considered a professional one. The therapist's professional code of ethics prohibits any other relationship between the therapist and the client, including any non-counseling activity initiated by either the therapist or the client for the purpose of establishing a non-therapeutic relationship, such as social contact.

ARTIFICIAL INTELLIGENCE (AI) DOCUMENTATION NOTICE: Our practice uses artificial intelligence (AI) technology within our electronic health record (EHR) system to assist with administrative and clinical documentation, including the dictation and transcription of office visits.

AGREEMENT:

By signing below, I acknowledge that I have read, understood and agree to everything in this Agreement, and authorize payment to APC's Behavioral Health Services. I also authorize APC's Behavioral Health Services to release any information necessary to process my insurance claims or other billing to their agents.

_____ _____
Client Signature Date

_____ _____
Client Name Date

ADVANCED PAIN CARE

ASSIGNMENT OF BENEFITS (AOB), RELEASE OF INFORMATION (ROI) AND FINANCIAL AGREEMENT

Patient's Name: _____ Date of Birth: _____

Thank you for choosing **Advanced Pain Care and its sub-specialties, affiliated and related entities** your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy prior to seeing a medical care provider.

A patient's portion of payment, including co-pay, deductible, and/or balance on account is due at the time services are rendered unless prior arrangements have been made with the Billing Department.

We accept assignment with most major insurance companies and participating provider plans. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier. We verify your benefits as a courtesy and do not guarantee coverage or payment.
2. All charges are your responsibility whether your insurance company pays or not.
3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
5. Returned checks will be subject to a $25.00 collection charge. If the check is not picked up within 10 days, the check may be turned over to law enforcement.
6. Office visit no shows without 24-hour notice, are subject to a $25.00 charge.
7. Paperwork requiring completion by a provider will incur a $75.00 charge. Including but limited to disability, FMLA, etc.
8. Unpaid balances over 90 days may be subject to collection via small claims court, attorney, and/or collection agency with applicable collection fees. All collection fees are the responsibility of the patient.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate about any such problems so that we can assist you in the management of your account.

Procedure No Show, Cancellations & Reschedules within 72 hours:
At the time of scheduling, a credit card will be obtained and securely placed on file. Failure to show on the scheduled day, or cancellation or rescheduling made within 72 hours of the procedure, will incur a $75 fee.

Authorization to Release Billing Information and Assignment of Insurance Benefits: I authorize release of **ANY** medical information, including substance abuse, mental health, and HIV/AIDS records, required to act on **ANY** medical insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to **Advanced Pain Care and its sub-specialties, affiliated and related entities** the medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare and Medicaid. This authorization is in effect for all future claims, until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment. I have had the opportunity to ask and have my questions answered to my satisfaction.

Patient Signature_____ Date: _____

Relationship to patient if not patient _____

Mark Malone MD PA includes Advanced Pain Care and sub-specialties, affiliated and related entities.

ADVANCED PAIN CARE

NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ *Date of birth:* _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain PATIENT RIGHTS with respect to my protected health information.

I understand that Advanced Pain Care and its subspecialty, Advanced Surgical Center , may use or disclose my protected health information for treatment, payment, or health care operations, which means: providing health care to me, the patient; managing billing and payment; and handling other health care operations. Except as required by law, there will be no other uses or disclosures of this information without my permission.

I authorize Advanced Pain Care and its Subspecialty, Advanced Surgical Center to communicate with me **PCP** *(Primary Care Physician)***: Dr.**_____ Phone #: ( ) _____

Advanced Pain Care and its subspecialty, Advanced Surgical Center, have a detailed document called a ***'Notice of Privacy Practices'***. It contains a more complete description of your privacy rights and how we may use and disclose protected health information.

I understand that I have the right to read the ***'Notice of Privacy Practices'*** before signing this agreement. If I ask, Advanced Pain Care and its subspecialty, Advanced Surgical Center, will provide me with most of ***the current 'Privacy Consultations'.***

My signature below indicates that I have been given the opportunity to review such a copy of the ***'Notice of Privacy Practices'.*** My signature signifies that I agree to allow Advanced Pain Care and its subspecialty, Advanced Surgical Center , to use and disclose my protected health information to carry out treatments, payments, and health care operations. I have the right to revoke consent in writing at any time, except to the extent that Advanced Pain Care and its subspecialty, Advanced Surgical Center , have taken action based on this consent.

_____ _____

Patient's signature ***Date***

_____ _____

Patient Relationship if signed by another party ***Date***

You may obtain a copy of our ***'Notice of Privacy Practices'***, including any revisions to our ***'Notice of Privacy Practices'.*** at any time by contacting: Advanced Pain Care and its subspecialty, Advanced Surgical Center at 2000 S. Mays St, Round Rock, Texas 78664 or (512) 244-4272.

OFFICE USE ONLY ****

Staff initials below when completed

Consent dates have been updated in Athena _____

ADVANCED PAIN CARE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____

- I authorize Advanced Pain Care and it's sub-specialties to release information from my Medical Record as described in this form.
- Many of our patients allow family members to call and discuss medical information, request prescription refills, medical records, and results of tests, pick up forms, etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members you must sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Check all that apply to the above names:

Failure to designate any limitations on the release of PHI below shall result in authorization to release all medical records.

- ☐ Regarding appointment, time & date
- ☐ Discuss medical care, an issue or concern
- ☐ Discuss Billing Information
- ☐ Discuss Lab Results
- ☐ Pick up Prescriptions
- ☐ Discuss Imaging Results
- ☐ Pick up Forms

RIGHT TO REVOKE: *I understand that I can withdraw at any time by giving written notice stating my intent to TERMINATE this authorization to **Advanced Pain Care 2000 S. Mays St., Suite 201 Round Rock, TX 78664**. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my Medical Record will not be affected. I understand that Advanced Pain Care will not condition treatment on whether I sign this authorization.*

SIGNATURE AUTHORIZATION: *I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop release of Medical Record that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.*

This authorization will expire in 1 year from the date of signature unless another date is specified: _____

Patient Signature	Date
Legally Authorized Representative	Relationship to Patient

ADVANCED PAIN CARE

Quality: Demographics

Patient Name: _____ **DOB:** _____

Language

☐ English ☐ Spanish ☐ Other:_____

Race

☐ American Indian or Alaskan Native
☐ Asian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Black or African American
☐ White or Caucasian
☐ Native Hawaiian
☐ Multi-Racial
☐ Other:_____

Ethnicity

☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Marital Status

☐ Married ☐ Single
☐ Widowed ☐ Partner

Portal Email

Please provide email for patient portal access: _____

Consent to Text, Call and leave detailed voice messages

Do you give Advanced Pain Care permission to text you? ☐ Yes ☐ No

Do you give Advanced Pain Care permission to call you? ☐ Yes ☐ No

Consent for communication of medical information via voice message

Do you give Advanced Pain Care permission to leave a detailed voice message on your phone regarding your healthcare? This may include but is not limited to information about upcoming surgical procedures, appointment information, payment information, lab results, and other health-related information. ☐ Yes ☐ No

_____ _____

Patient Signature *Date*

****** OFFICE USE ONLY ******

Staff initial below when completed

Race / Ethnicity / Language updated in Athena _____

Portal Registration: Y or N If no, did they decline and you printed portal URL? Y or N _____

ADVANCED PAIN CARE

Patient's Name: _____ **Date of Birth:** _____

Notice Informing Individuals About Nondiscrimination and Accessibility

Discrimination is Against the Law

Advanced Pain Care/Advanced Surgical/Advanced Pharmacies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)) [optional: (or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Advanced Pain Care/Advanced Surgical/Advanced Pharmacies does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Advanced Pain Care/Advanced Surgical/Advanced Pharmacies:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Michael Jensen, Compliance Officer and Civil Rights Coordinator.

If you believe that Advanced Pain Care/Advanced Surgical/Advanced Pharmacies has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Michael Jensen, Compliance Officer and Civil Rights Coordinator, 101 Louis Henna Blvd., Ste 300, Austin, TX 78278, Tel: 512-244-4272, Fax: 512-244-2895, or at compliance@advancedpaincare.us.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Michael Jensen, Compliance Officer and Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at Advanced Pain Care's website: https://austinpaindoctor.com

By signing below, I acknowledge that I have been given this notice.

Patient Signature: _____ **Date:** _____