MHP
MILE HIGH PSYCHIATRY

Consent for Treatment through Tele-Psychiatry

Tele-Psychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems between a provider and a client that are not in the same physical location. The interactive electronic systems used in Tele-Psychiatry incorporate network and software security protocols to protect the confidentiality of client information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. Telepsychiatry may be appropriate and possible for certain situations and medical needs, while not appropriate or possible in others. The use of Tele-Psychiatry will be determined on a case-by-case basis by the provider. The provider will always act in the best interest of the patient and shall place the health, safety, and welfare of the patient first when making a determination on the use of Tele-Psychiatry.

Potential Benefits:

- Increased accessibility to Psychiatric care
- Increased continuity of care between provider and patient
- Client convenience

Potential Risks: Due to the inherent limitations of Tele-Psychiatry, there may be potential risks associated with the use of Tele- Psychiatry. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g. poor resolution of video, hardware, software, or equipment problems) to allow for appropriate decision making by your provider
- Your provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment
- Security protocols protecting confidential information can be more at risk, causing a breach of the privacy of confidential health information - A lack of access to all the information that might be available in a face to face visit but not in a Tele-Psychiatry session, may result in errors in judgment

Client Rights:

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to Tele-Psychiatry
- I have the right to withhold or withdraw my consent to use Tele-Psychiatry during the course of my care at any time. I understand that my withdrawal of consent will not affect my future care or treatment
- I understand that my provider has the right to withhold or withdraw consent for the use of Tele-Psychiatry during the course of my care at any time
- I understand that all rules and regulations that apply to the provision of healthcare services in the state of Nevada also apply to Tele-Psychiatry

Client Responsibilities:

- I will not record any Tele-Psychiatry sessions without written consent from my provider
- I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins
- I understand that I alone am responsible for the configuration of any electronic equipment used on my electronic device that is used for Tele-Psychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins
- I understand that I must be a resident of the State of Nevada to be eligible for Tele-Psychiatry services from my provider
- I understand that I must be physically in the State of Nevada at the time of any scheduled Tele-Psychiatry appointment

By signing below, you certify that you have read and understand the terms as stated in the Treatment Consent Form, Prescription Policy, Consent for Tele-psychiatry, Attendance Policy and Advanced Directives. You Indicated that you understand the scope of our services, session structure, fees, cancellation/no –show policies, payment policy, insurance reimbursement, confidentiality, the nature of our practice, our contact information and that you agree to abide by the terms stated above during the course of our therapeutic relationship.

Client Name (Printed): _____

Client Signature: _____ Date:_____

Parent/Guardian Signature *(If applicable)*: _____ Date:_____

POLICIES AND GUIDELINES

Our policies and guidelines are available as PDFs accessible through the links below. Alternatively, the documents are always available at milehighpsychiatry.com/patient-resources

Services Offered:

Mile High Psychiatry Services

Patient Responsibilities:

Attendance Policy
Cancellations and No-Shows
Payments, Fees, and Insurance

Requests, Policies, and Prescriptions:

Mile High Psychiatry Requests & Policies
Prescription Policy

Advance Directives:

Mile High Psychiatry Advanced Directives

MHP
MILE HIGH PSYCHIATRY

Patient Demographic Form

Last Name First Name Middle Nickname

____/____/_____ ❑ Male ❑ Female ❑ Non-Binary_____

DOB Gender SSN

❑ Married ❑ Single_____

Marital Status Ethnicity Preferred Language Pronouns

Home Address Apt # City State Zip Code

Home Phone Cell Phone Work/School Phone

Email Address Referral Source *(Please Specify)*

Employer/School Name

Emergency Contact Information

Last Name First Name Relationship to Patient

Home Address Apt # City State Zip Code

Home Phone Cell Phone Work/School Phone

Email Address

Insurance Information

Primary Insurance Member ID Secondary Insurance Member ID

Preferred Pharmacy Phone Number Address

Responsible Party/Guarantor Information

Relationship to Patient: ❑ Self (If Self, skip this section) ❑ Spouse ❑ Parent ❑ Other

❑ Male ❑ Female

Last Name First Name Middle Initial Gender

Home Address Apt # City State Zip Code

MHP
MILE HIGH PSYCHIATRY

HIPAA Privacy Release of Information Authorization Form

I hereby authorize and request to furnish the protected health information of:

Patient Name: _____ Patient DOB: _____
Social Security #:_____ Phone Number:_____
Address: _____ City: _____ State: _____

You may use or disclose the following health care information *(check all that apply)*:

❏ All my health information
❏ All my health information **except**:
- ❏ Mental Health Records
- ❏ Communicable Diseases (including HIV or AIDS)
- ❏ Alcohol/Drug abuse
- ❏ Lab Results

❏ Other: _____

I authorize for release of PHI covering the period of healthcare

❏ From (date) _____ to (date) _____
❏ All past, present, and future periods

Reason for this authorization:_____

This section is only applicable when records are being released from one organization/practice to another.

Release Records **FROM**:

Name:_____
Address:_____ City:_____ State: _____
Phone:_____ Fax:_____ Email: _____

Send Records **TO**:

Name:_____
Address:_____ City:_____ State: _____
Phone:_____ Fax:_____ Email: _____

I authorize disclosure of information regarding my billing, condition, treatment, and prognosis along with my PHI as I have selected above to the following individuals:

Name:_____ Phone:_____ Relationship:_____
Name:_____ Phone:_____ Relationship:_____
Name:_____ Phone:_____ Relationship:_____
Name:_____ Phone:_____ Relationship:_____

I have carefully read and understood the above, have had any questions answered to my satisfaction, and do hereby voluntarily authorize disclosure of the above information or medical records of my conditions to those persons or organizations listed above. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal or state law.

This release is effective until(Date) _____. I may revoke this release in writing at any time._____(Initials)

Patient or Legally Authorized Representative Signature	Relationship to patient	Date

ACH Authorization Form

CREDIT/DEBIT AUTHORIZATION FORM (This form is NOT optional)

I hereby authorize Mile High Psychiatry to withdraw via credit/debit card and, if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until Mile High Psychiatry is notified by me (us) in writing to cancel it in such time as to afford Mile High Psychiatry a reasonable opportunity to act on it.

*** I also authorize my credit/debit card to be used in the event of a missed appointment or last minute reschedule/cancel appointment. I agree to the full cost of the visit ($175 - $220 for follow up visits and $275 - $305 for intake visits). ***

Card holders name: _____

Card Holders Address: _____

Patient Name: _____

Card Number

Expiration Date: _____ CVV: _____

* American Express has 15 digits, with a 4 digit CVV *

Cardholder's Signature: _____ Date: _____

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Column Totals	_____	+ _____	+ _____	
Add Totals Together	_____			

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)