NEW BEGINNINGS
Mental Health and Wellness

OFFICE POLICIES AND PROCEDURES

NEW BEGINNINGS MENTAL HEALTH AND WELLNESS WELCOMES YOU TO OUR PRACTICE!
BELOW IS SOME INFORMATION REGARDING OUR POLICIES AND PROCEDURES:

Office Hours:
Monday – Thursday 8:30 AM – 5:00 PM. Closed on Fridays and major holidays.
Additional telehealth appointment hours may be available as well (other times may be made available per request).
Please arrive to your appointment on time. If you are going to be late, please let us know so we can try to work you into the schedule or reschedule the appointment. If you are more than 15 minutes late for a follow up appointment and 30 minutes late for an initial appointment, you will be charged a no-show fee and be required to reschedule.

No Show Fee:
We want to ensure that our patients make their appointments since there is a limited number of patients that can be seen per day. If you cannot make your scheduled appointment, please let us know 24 hours in advance by call, text, or email. A missed appointment without notice will result in a $75 “no show” fee.

Medical Information:
Please bring all medications with you to your appointment and let us know of any changes to your medical information to ensure that we have the most accurate and up to date information for your record.

Prescriptions:
It is our intent to provide refills of your medications at your appointment to last you until your next follow-up appointment. To ensure you do not run out of medication, please keep your scheduled follow-up appointments and let the provider know which medications need refills during the appointment.

Insurance/Billing:
If we are not in network with your insurance company, payment will be due at the time of the office visit. If you are self-pay, the full amount of the visit is due at the time of the services. Payments are made by credit and debt cards only. You must enter your payment information into your Grow Therapy portal.

Past Due Balances:
All accounts with a balance will be expected to be paid prior to scheduling an appointment. All co-pays and deductibles will be charged at the time of your office visit. Please be aware of your insurance coverage and policy information.

I have read and agree to the above New Beginnings Mental Health and Wellness Policies and Procedures.

_____	_____	_____
Printed Patient Name	Date	Signature of Patient

*If signing as a legal guardian, you are verifying that you are giving consent to the above listed conditions for your minor.

NEW BEGINNINGS
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information (PHI)
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

PHI includes information that we create or receive about your past, present, or future health or condition, the provision of health care to you, or the payment for health care provided to you. In general, we may not use or share anymore PHI than is necessary to accomplish our purpose.

Described as follows are the ways we may use and disclose health information that identifies you. Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission with a written request.

- **Treatment**: We may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
- **Payment**: We may use and disclose PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may share PHI with your health plan to get paid for the health care services we provided to you. We may also share PHI with billing companies and companies that process our health care claims.
- **Health Care Operations**: We may use and disclose PHI for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We may also share information with our accountants, attorneys and others in order to make sure we are complying with the laws that affect us.

OTHER USES OF PHI

- **Reports required by law**: We may report PHI when the law requires us to give information to government agencies and law enforcement about victims of abuse, neglect, or domestic violence or required in a legal proceeding.
- **Public health**: We may report PHI about births, deaths, and other diseases to government officials in charge of collecting that information. We may provide PHI relating to death to coroners, medical examiners, and funeral directors.
- **Health oversight**: We may report PHI to assist the government when it investigates or inspects a health care provider or organization.
- **Organ Donation**: We may notify organ banks to assist them in organ, eye, or tissue donation and transplants.
- **To avoid harm**: We may report PHI to law enforcement, in order to avoid a serious threat to the health or safety of a person or the public.
- **Other government functions**: We may report PHI for certain military and veterans' activities, national security and intelligence purposes, protective services for the President of the United States, or correctional facility situations.

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NOTICE OF PRIVACY PRACTICES

Your Rights

You have the following rights regarding health information we have about you:

- **Your rights to request limits on our use of PHI**: You may ask that we limit how we use and share you PHI. We will consider your request but are not legally required to agree to it. If we agree to your request, we will follow your limits, except in emergency situations. You cannot limit the uses and reports that we are legally required or allowed to make. To request a restriction, please notify us immediately.
- **Right to Request Confidential Communication**: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request in writing to the Office Manager. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
- **Right to view and get a copy of your PHI**: You may view or obtain a copy of your PHI (except for mental health notes). Your request must be in writing. We will reply to you within 30 days of your request. If you request a copy of your PHI, we may charge a fee. Instead of providing the PHI you requested, we may offer to give you a summary or explanation of the PHI, as long as you agree to that and to the cost in advance.
- **Rights to a list of the reports we have made**: You have the right to get a list of the parties to whom we have reported you PHI. The list will not include reports for treatment, payment, or health care operation; reports you have previously authorized: reports made directly to you or to your family; reports made for national security purposes; reports to corrections or law enforcement personnel; or reports made before March 16, 2020.
- **We will respond to your request within 60 days**: we will include the reports made in the last six years unless you request a shorter time. The list will include the date of each report, the identity of the person (s) receiving the report, the type of information reported, and the reason for the report.
- **We will not charge you for the list**: If you make more than one request in the same year, however, we may charge you a fee for each additional request. For a list, you must make a request in writing to the Office Manager.
- **Right to correct or update you PHI**: If you feel that there is a mistake in your PHI, or that important information is missing, you may request a correction. Your request must be in writing and include a reason for the request. We will respond within 60 days of your request. We may deny your request if the PHI is, 1) correct and complete, 2) not created by us, 3) not allowed to be shared with you, or 4) not in our records. If we deny your request, we will inform you of the reason for the denial. You may then file a written statement of disagreement, or you may ask that your original request and our denial be attached to all future reports of your PHI.

Uses and disclosures not described in this Notice of Privacy Practices will be made only with your authorization.

Please sign to acknowledge that you have had an opportunity to receive this Notice and to ask questions regarding its contents. Signing this Acknowledgment form in no way affects the care you will receive.

_____	_____	_____
Print Patient Name	Date	Signature of Patient

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TREATMENT AUTHORIZATION AND AGREEMENT

· I hereby voluntarily request, consent to, and authorize New Beginnings Mental Health & Wellness' clinicians to provide confidential medical treatment including, but not limited to, administration of medications as deemed necessary and advisable.

· I understand that the 2019 novel coronavirus, which causes the disease COVID-19, has been declared a pandemic by the World Health Organization, is extremely contagious, and is believed to be spread by person-to-person contact. I recognize that the staff of New Beginnings Mental Health & Wellness has put in place reasonable preventative measures aimed at reducing the spread of COVID-19. However, I recognize and accept the risk of becoming infected by virtue of seeking services in-person at New Beginnings Mental Health & Wellness.

AGREEMENT TO PAY FOR SERVICES

· I authorize New Beginnings Mental Health & Wellness to release the necessary medical information to Medicare, Medicaid, or other insurance carriers to process claims and further authorize payment of medical benefits payable directly to New Beginnings Mental Health & Wellness.

· I understand that New Beginnings Mental Health & Wellness will file and complete necessary steps to collect my insurance payment.

· I understand that I am responsible for any account balance that is not covered by insurance or for any services rendered at New Beginnings Mental Health & Wellness. This includes any deductibles or co-payment portions of my bill.

AUTHORIZATION & CONSENT TO ACCESS, USE, & DISCLOSURE OF PROTECTED HEALTH INFORMATION TO/FROM NEW BEGINNINGS MENTAL HEALTH & WELLNESS

· I consent to and authorize New Beginnings Mental Health & Wellness to store my personal protected health information in an electronic health record.

· I consent to New Beginnings Mental Health & Wellness and its designees accessing through and/or disclosing my individually identifiable health information to the electronic health record.

_____	_____	_____
Printed Patient Name	Date	Signature of Patient

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Fee Schedule

Initial Psychiatric Evaluation	$200 – self pay rate
Follow-up Psychiatric Visit	$125 – self pay rate
Prescription Refill Service Outside of Appointment	$50
Misc. Provider Services *	$75 per 15 minutes
No Show Fee	$75

*Some examples of misc. provider services include letter preparation, clinical phone calls, clinical emails, and appointments that extend beyond the scheduled time frame. If you have questions about what is being billed, please contact us.

NOTE - We will bill your insurance, unless you are self-pay or out of network, for your initial and follow-up appointments. All other services will be billed to you directly, via Stripe.

Payment methods include credit or debit card only.

I agree to the fee schedule above. I understand that I am responsible for any account balance that is not covered by insurance or for any services rendered at New Beginnings Mental Health & Wellness.

_____ _____ _____

Printed Patient Name Date Signature of Patient

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PATIENT CONSENT TO TELEMEDICINE SERVICES

PLEASE READ EACH SECTION CAREFULLY. YOU MAY REQUEST A COPY OF THIS FORM FOR YOUR OWN RECORDS.

Introduction: Telemedicine involves the real-time evaluation, diagnosis, consultation on and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real time. There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand I can ask questions and seek clarification of the procedures and telemedicine technology at any time.

Consent for treatment: I voluntarily request New Beginnings Mental Health and Wellness and its physicians, nurses, associates, technical assistants, and other health care providers as it may deem necessary (collectively "Practice") to participate in my medical care through the use of telemedicine.
I understand that Practice (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I further acknowledge my failure to accurately and completely relay information about my medical history, condition and care may adversely impact New Beginnings Mental Health and Wellness' advice, recommendations, or decisions about my care. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.
I understand that if New Beginnings Mental Health and Wellness determines in its reasonable professional judgment that telemedicine services will not adequately address my medical needs, I may be required to complete an in-person medical evaluation. I also understand that in the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented, or an in-person medical evaluation may be necessary. Finally, if I experience an urgent matter after a telemedicine session, such as a bad reaction to a treatment, I should alert my treating provider and, in the case of emergencies, dial 911 or go to the nearest hospital emergency department.

Release of information: To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of my Personal Information (defined below) to New Beginnings Mental Health and Wellness. I understand this disclosure may include my name, address, contact and demographic information, general health status and treatment information, images, individually identifiable health information or protected health information, and other information related to my health or condition (collectively "Personal Information").
I understand that the disclosure of my Personal Information to New Beginnings Mental Health and Wellness, including the audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

Right to withdraw consent: I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time.

NEW BEGINNINGS
Mental Health and Wellness

PATIENT CONSENT TO TELEMEDICINE SERVICES

I have read this Telemedicine Consent in its entirety and agree to be bound by all of its terms and conditions as described above.

_____	_____	_____
Printed Patient Name	Date	Signature of Patient

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Mental Health and Wellness

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATION INFORMATION

I, the patient, authorize New Beginnings Mental Health and Wellness to use or disclose my protected health information for the purpose of treatment, payment, or healthcare operations as the terms are defined under federal HIPAA privacy rules.

• I have the right to revoke this consent; such revocation must be submitted to New Beginnings Mental Health and Wellness in writing. The revocation shall be effective except to the extent that New Beginnings Mental Health and Wellness has already taken action in reliance on the consent.

• I have received a copy of New Beginnings Mental Health and Wellness "Notice of Privacy Practices" as required by HIPAA.

• I understand, acknowledge, and agree to the information above.

If you would like for New Beginnings Mental Health and Wellness to disclose your health information (medical condition, diagnosis, treatment, payment, healthcare options) to anyone, please list their names, numbers, and relationship to you below:

Name	Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____

Printed Patient Name Date Signature of Patient

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

If you have any doctors that you would like us to request medical records from, please fill in the line below with their name. Request additional forms if needed.

_____
(Previous Doctor's Name/Clinic Name)

I hereby authorize the release of my medical records to New Beginnings Mental Health and Wellness. Please include all medical treatment within the past year, including laboratory test results for continuity of care.

_____	_____	_____
Printed Patient Name	Date of Birth	Social Security Number

_____	_____
Signature of Patient	Date

New Beginnings Mental Health and Wellness
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