



MyNDSpace– Clinic Policies/HIPAA

Patient Name: _____ Date of Birth: ____/____/____

What to Bring to Your Appointment(s):

- Photo Identification/Driver's License (provide update copies if any changes occur)
- Insurance Identification Card
- Completed Intake Paperwork Packet

Prescription Policy: Our clinic will only refill prescriptions at the time of a scheduled appointment. Please be proactive in monitoring the need for refills. We do not respond to fax requests for prescriptions refills.

Availability of Providers: We do not provide 24/7 call-coverage at our office. Please note that in case of emergency, we advise you to call 9-1-1 or go to your local emergency room.

Billing Service: Please note that MyNDSpace utilizes an outside agency for the purposes of billing and submitting claims to insurance providers. These individuals are provided limited access to patient demographics as required for the billing process and also maintain appropriate HIPAA compliance. We will work to assist in explaining balances in office.

HIPAA

MyNDSpace is required by the Health Insurance Portability & Accountability Act (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by MyNDSpace, and of your individual rights and our legal duties with respect to confidential information.

Release of Information: Please complete the attached release of information form to indicate any parties to which you wish to have your protected health information (PHI) released. Other than the indicated parties, our clinic may release the information for payer-source purposes (insurance companies).

Disclosures that do not require authorization to release your PHI:

- Disclosure required by law, such as a court order by a judge.
- Disclosure for use in judicial or administrative proceedings, such as a malpractice case or board complaint.
- Disclosure to maintain safety of patients or others, such as communication with probate court for commitment.
- Disclosure during emergent care situations, such as discussing care with emergency room providers.
- Disclosure for suspected abuse, neglect or domestic violence, as required as a mandated reporter and for duty to warn.

I hereby attest to having read the above information in its entirety and understand my rights as a patient as well as the policies of MyNDSpace Mental Health Education & Consulting, LLC.

Signature of Patient/Guardian: _____ Date: _____

MyNDSpace Release of Information

Patient Name: _____ **Date of Birth:** ____/____/____

Please document below parties that you would allow medical information to be released to. It is often helpful in coordination of care if other providers are indicated on this list. Thank you!

Name of Person	Relationship to patient	Telephone Number	Medical Information	Appointments

Pharmacy Name/Location: _____ **Phone:** _____

**Release of information pertaining only to appropriate prescription information*

Permission to Call Home or Cell?	Yes	No	Preferred #:
Permission to Leave Voicemail?	Yes	No	
Permission to Email	Yes	No	Email:
Permission for Reminder call/text	Yes	No	Preferred method:

HIPAA and Email: Please note that many popular email services (Gmail, yahoo, Hotmail) do not utilize encrypted email. When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet.

For Minors:

Due to concerns with custody, please state who has medical decision-making capacity.

If this is not the current representative, do you give permission for any other parent/guardian to make medical decisions? Yes No

Name of person(s): _____

I hereby authorize the release of the medical information as documented above. I understand I retain the right to decline release of information to the above parties at any time and will notify staff of any changes that I wish to make in writing. I understand that in emergency situations the provider may contact other providers/caregivers to coordinate safe and appropriate care without my consent.

Signature of Patient/Guardian: _____

Date: _____

MyNDSpace– Financial Responsibilities

Patient Name: _____ Date of Birth: ____/____/____

Below is a summary of the financial responsibilities for you as a patient here at MyNDSpace.

Patients are responsible for any remaining balances that will be represented from our billing services. We do our best to help estimate patient costs including co-pays, co-insurance, deductibles and out of pocket limits. The information provided is often not up to date when patients present to the clinic, and we do our best to work with the information provided to us. Please contact your insurance company for clarification of benefits prior to your office visits to better understand your benefits as an individual.

Insurance Filing: Please note that we will file your claims with the insurance providers as a courtesy. We require that you provide a current ID and copy of the insurance card. These may change over time, and we require that you inform us of any changes and provide copies of new insurance cards/information. It is important that we have the most up to date information as any errors in your information can result in denied claims. This includes insurance policy ID numbers, address changes, DOB, social security number, and telephone numbers. **Please note that you will be responsible for the balance due with denied claims.**

Insurance Verification: Please be sure to verify coverage prior to your first visit. You as a patient are responsible for understanding your benefits for coverage. Our staff will work to provide verification of insurance benefits prior to the first visit. This helps to assure that the provider you are seeing is covered with your benefits. You are responsible for knowing your current insurance requirements for verification and coverage. Some carriers require verification, referrals from another provider (PCP), or updates when you change providers. Please feel free to contact our staff as we can help assist with any questions.

Payment is due at the time of the office visit. There may also be remaining fees as a result of insurance coverage, denied claims or other fees listed below.

Early Refills: Requests for early refills are subject to provider discretion and require an appointment.

Drug Screening: It is our policy to conduct periodic drug screens. Drug screens may be collected via oral swab or urine specimen. In the event that drug screens are not covered by your insurance provider, you will be subject to an additional fee of \$25.00 at the time of screening.

Cancellation/No-show Policy: It is our policy that you are responsible for being aware of your upcoming appointments. We understand that certain circumstances arise that can result in the need to reschedule an appointment. We require 24-hour notice for cancellations, otherwise you may be charged a \$50 fee for not showing up to your scheduled appointments. Please call the office at any time at (843)266-7573 or email at admin@myndspace.org. If you are unable to reach us, please feel free to leave a message. We will return the call when time allows. If you do not hear back, please call again to confirm that the appointment has been rescheduled.

Office/Administrative Fees: Please note that office staff is often required to provide documentation to patients, providers and outside agencies. The following are rates for the services rendered to complete that service.

Letters/Forms/Completed Paperwork for outside agencies: \$25.00

Copies of Medical Records: \$30 per page

I hereby acknowledge that I have read all of the above information regarding my responsibility as a patient at MyNDSpace, and I agree to these terms.

Patient/Guardian Signature: _____ Date: _____

MyNDSpace Intake Form

Name _____ Date _____

What are the problem(s) for which you are seeking help?

1. _____
2. _____
3. _____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Poor focus | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Distractibility | Anxiety attacks |
| <input type="checkbox"/> Sleep pattern disturbance | <input type="checkbox"/> Increase risky behavior | <input type="checkbox"/> Interrupting others | Avoidance |
| <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Getting off task | Hallucinations |
| Concentration/forgetfulness | <input type="checkbox"/> Decreased need for sleep | <input type="checkbox"/> Mood Swings | Suspiciousness |
| Change in appetite | <input type="checkbox"/> Excessive energy | <input type="checkbox"/> Checking Behaviors | Other: |
| Excessive guilt | <input type="checkbox"/> Increased irritability | <input type="checkbox"/> Difficulty in crowds | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Crying spells | <input type="checkbox"/> Nightmares | |
| <input type="checkbox"/> Decreased libido | | | |

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? Yes No

No. If YES, please answer the following. If NO, please skip to the next section.

Do you **currently** feel that you don't want to live? Yes No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Is there anything that would stop you from killing yourself? _____

Have you ever tried to kill or harm yourself before?

Do you have access to guns? If yes, please explain. _____

Current Psychiatric Medications: Please list Name, Dose and Times of Day

Past Psychiatric Medications: Please list Name, Dose and What you remember about the effect.

Psychiatric Hospitalization () Yes () No If yes, describe for what reason, when and where.

Reason

Date Hospitalized

Where

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? Yes No

If yes, for which substances? When?

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	()	()	_____
Cocaine	()	()	_____
Stimulants (pills)	()	()	_____
Heroin	()	()	_____
LSD or Hallucinogens	()	()	_____
Marijuana	()	()	_____
Pain killers (not as prescribed)	()	()	_____
Methadone	()	()	_____
Tranquilizer/sleeping pills	()	()	_____
Alcohol	()	()	_____
Ecstasy	()	()	_____

Consent for Behavioral Health Treatment

Consent to Services: I voluntarily consent that I will participate in a behavioral health treatment (e.g. psychological or psychiatric) by staff from MyNDSpace Mental Health Education & Consulting, LLC. Treatment may be provided by a licensed counselor, a psychologist, a psychiatric nurse practitioner, a psychiatrist, or an individual supervised by any of the professionals listed. Services may include interviews, assessment or testing, psychotherapy, and/or medication management.

Risks & Benefits: Behavioral health treatment has both benefits and risks. Risks may include experiencing uncomfortable feelings because the process often requires discussing difficult aspects of one's life. However, treatment has been shown to have benefits. It often leads to a significant reduction in feelings of distress, increased satisfaction in relationships, greater awareness and insight, increased skills and resolutions to specific problems. Some individuals may not improve because of treatment or may terminate before it is clinically indicated. In addition individuals may experience side effects from psychotropic. It is important to keep your clinician advised of any difficulty you may encounter during your treatment.

Treatment Compliance: After 3 repeated absences/failure to participate in services may result in discontinuation of services. If you are not scheduling sessions and/or arriving for sessions for a continuous period, we will assume you are voluntarily terminating services with us. After 6 months, you will be required to participate in another intake and assessment process.

Cause for Termination: If it is deemed that the services we provide are not beneficial for you, a decision could be made to discontinue services. Disorderly Conduct, Threatening Behavior, and/or failure to treat other clients and staff with respect can result in discharge from our services. Failure to maintain the confidentiality of others accessing services can result in discontinuation of services. MyNDSpace reserves the right to discharge clients for reasons not mentioned in this informed consent, should the need arise. Such dismissal from services would not happen without justifiable cause.

Emergency Contact: Please provide contact information for individuals we may contact on your behalf.

Name: _____ Phone Number: _____

Relationship to Patient: _____

Name: _____ Phone Number: _____

Relationship to Patient: _____

I have read and understand all conditions set forth in this Informed Consent. I consent to participate in MyNDSpace Mental Health Services.

I have read and agree with the conditions set forth in the Informed Consent. I agree to allow my minor child (name of minor) to participate in MyNDSpace Mental Health Services.

Client/Parent Signature _____ Date _____

Witness Signature _____ Date _____

Expiration of Consent: This consent will expire at the time of discharge from behavioral health services from MyNDSpace Mental Health Education & Consulting, LLC.

2022 Informed Consent For Telemedicine Services

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

Practitioner Name: Cerissa Hugie
 Megan Mahoney
 Crystal Clevenger
 Other Staff: _____

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that if I am in such mental or emotional condition to be a danger to myself or others, my physician has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.
3. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
4. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
5. I understand that it is my duty to inform MyNDSpace of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
7. My practitioner will respond to communications and routine messages within 48-72 hours on business days or on the next business day following weekends, holidays, or vacations.
8. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.
9. The laws and professional standards that apply to in-person outpatient services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.
10. I attest that I am a resident and or located in the state of South Carolina and will be present in the state of South Carolina during all telehealth encounters with MyNDSpace Practitioners.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize MyNDSpace Mental Health Education and Consulting to use telemedicine in the course of my diagnosis and treatment.

**Patient's Signature
(Or Authorized Person To Sign For Patient)**

Date

If Authorized Signer, Relationship To Patient

Physician's/Practitioners Signature

Telemedicine Protocol for MyNDSpace

Service: Telepsychiatry services are provided by the practitioners at MyNDSpace Mental Health Education and Consulting, from a distant site equipped with a secure two-way, real time interactive telecommunication system (TriMed/Doximity) to a member in a qualifying originating site i.e. home (Resident of South Carolina).

Provider: MyNDSpace Treatment Team; Psychiatrist and/or Psychiatric Mental Health Nurse Practitioner, licensed professional counselors, licensed social workers, substance abuse counselors and physician assistants

Provider Location: Primarily at MyNDSpace medical office which is located at 4 Carriage Lane Ste. 200 Charleston, SC 29407. Access will be done through TriMed/Doximity.

Eligible Medical Services: Services that are eligible for reimbursement include consultation, office visits, individual and family psychotherapy and pharmacologic management delivered via a telecommunications system. The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual/family psychotherapy and pharmacologic management.

Services: Telemedicine clinicians at MyNDSpace will provide a full range of psychiatric services via teleconferencing technology to patients, including assessment, screening, diagnosis, psychotherapy and treatment of patients and determining the degree of disabilities in patients. The Psychiatrist and/or Psychiatric Mental Health Nurse Practitioner will be providing psychiatric interventions including monitoring and management of their psychiatric condition to include medication management. The psychiatrist, psychiatric mental health nurse practitioner, licensed professional counselors, licensed social workers, substance abuse counselors and physician assistants will provide supportive psychotherapy and psychoeducation about diagnosis, possible comorbidities, prognosis including, treatment plan/options and possible complications of the disease, and psychiatric interventions.

Psychiatrist and/or Psychiatric Mental Health Nurse Practitioner will prescribe medication to patients as deemed necessary and will conduct periodic medication management and re-evaluations as deemed necessary. Additional services include the prescription, direction, and administration of psychotherapeutic treatments or medications to treat mental, emotional, or behavioral disorders, and if necessary ongoing collaboration with physicians, psychologists, social workers, psychiatric nurses, or other professionals to discuss treatment plans and progress.

Provider and Facility Guidelines: The psychiatrist and/or Psychiatric Mental Health Nurse Practitioner, licensed social workers, licensed professional counselors, substance abuse counselors, and physician assistants will practice within the scope of their specialty and practice within the standard of care for their area.

Assessment and diagnosis, psychotherapy and medication management should be consistent with generally accepted standards of practice for the treatment of the identified behavioral health condition.

Platform: The telepsychiatry program will be using TriMed/Doximity which is a HIPAA Compliant software services and solutions for video conferencing with patients. Patients will be invited by their designated providers to TriMed/Doximity account to conduct video conferencing during the patient scheduled appointment.

Reimbursement for Telepsychiatry

Telepsychiatry is covered by some health insurances, however please note that if your insurance does not cover this service, patients will be required to pay the full fee for service.

Agreement Of Financial Responsibility: All patients will be required to sign an agreement of financial responsibility as patients will be responsible for all payments owed to MyNDSpace Mental Health Education and Consulting for services rendered to them. Please note that patient is responsible for all copay, coinsurance and deductible amounts owed to practitioner(s) at the time service is rendered.

FEE SCHEDULE FOR TELEPSYCHIATRY:

Psychiatric diagnostic interview examination 90972 – \$200.00 (50 Minutes)
Outpatient Telehealth Pharmacologic Management –99213 GT-\$80.00 (15 min)
Outpatient Telehealth Pharmacologic Management –99214 GT-\$125.00 (25 min)
Individual Psychotherapy – 90837 - \$150.00 (53 min+)

Patient Signature: _____ Date: _____

No Surprises Disclosure

In compliance with the No Surprises Act that went into effect January 1, 2022, there is now a Federal requirement for Health Care Providers to inform all healthcare consumers of their Federal rights and protections against “surprise billing”.

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by a NON-PARTICIPATING/OUT OF NETWORK healthcare provider. This allows the option for consumers to make the choice to receive care from an in-network provider if one is available.

Additionally, there is a requirement to provide all healthcare consumers with a Good Faith Estimate (GFE) of the cost of services for the duration of treatment. It is difficult to determine the actual length of treatment for mental health care; therefore, the estimate is based on the average length of treatment.

There is also a list of fees that you may incur throughout your care at MyNDSpace that are in addition to direct counseling services and fees. These fees may occur due to the following (not an exhaustive list):

Late cancellation(anytime AFTER 24 HOURS)/Fail to Show fee: \$50.00

Medical records request: \$30.00

Completion of documents (FMLA, Disability, VA or other medical summary letters, etc): \$25.00

Urine Drug Screen- \$25.00

Please note our fees are reviewed biannually, you will be notified in advance of any changes. Consultation hourly fees includes billing for preparation time for meetings/appearances.

If you have any questions, you can contact our main office at the number listed above in this document. If you believe your rights as a health consumer have been violated, and you cannot come to an agreement with MyNDSpace, you can contact the Department of Health and Human Services at 1-877-696-6775 or www.cms.gov/nosurprises.

By signing, you are agreeing that you understand your Federal health consumer rights, and you understand the fee agreements in this document.

INSURANCE PAYMENT OPTIONS AND FEES

It is the client’s responsibility to ensure that all services are paid in a timely manner. The current regular fee for assessment services is \$200 for a psychiatric evaluation; medication management follow-ups range between \$75-95 and individual therapy services are \$65 for 30 minutes sessions and \$100 for 45 minutes-1 hour. For clients who have insurance, there are specific contract rates, deductibles, copays and/or coinsurance amounts, and if you don’t know the specifics of your policy, please contact your insurance carrier. There are additional non-clinical fees for reports and other documentation completion that are not covered by insurance, and they are the sole financial responsibility of the client. All co-pays, co-insurance, and deductibles are due at the time of service.

Cancellations and re-scheduled visits will be subject to a \$50 charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time. The standard meeting timeframe is 30-45 minutes.

Late cancellation fees are NOT billed to insurance or EAP companies, they are the sole financial responsibility of the client. If you cannot attend an appointment, please remember to cancel or reschedule 24 hours in advance. You will be responsible for the \$50 cancellation fee if you cancel your scheduled appointment less than 24 hours of the session. SELF-PAY AND OUT OF NETWORK DISCLOSURE.

In compliance with the No Surprises Act that went into effect January 1, 2022, there is now a Federal requirement for Health Care Providers to inform all healthcare consumers of their Federal rights and protections against “surprise billing”.

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by a NON-PARTICIPATING/OUT OF NETWORK healthcare provider. This allows the option for consumers to make the choice to receive care from an in-network provider if one is available.

Additionally, there is a requirement to provide all healthcare consumers with a Good Faith Estimate (GFE) of the cost of services for the duration of treatment. It is difficult to determine the actual length of treatment for mental health care; therefore, the estimate is based on the average length of treatment. More detailed information is included in the Good Faith Disclosure Document

Please note that your information can be securely stored by Athena, a HIPAA compliant Electronic Health Record System.

By signing this document, I agree to the above disclosures as it pertains to my financial account with MyNDSpace.

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time