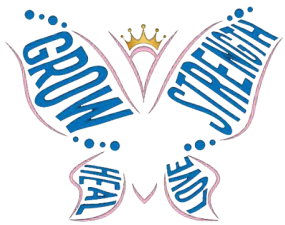

MONARCH MENTAL
HEALTH AND WELLNESS

Welcome to Monarch Mental Health and Wellness, LLC.

We are excited and honored to accompany you on your journey to feeling great. Please read the following practice expectations.

____Initial Paperwork Paperwork

- Paperwork must be completed before your first appointment.
- This may include, but is not limited to:
- Insurance information
- A copy of ID
- Practice expectations/agreements,
- Mental Health Scales, or a self-evaluation with history.

____Initial Psychiatric Evaluation

Your first appointment will consist of a detailed intake assessment. This includes a thorough history and requires 60 minutes of time. Please understand that it is important to determine if it appears that there will be a good fit with the client and provider or if another provider or specialist would be better suited. Please note that an intake evaluation does not guarantee that you will be accepted as a client or that you will be prescribed medication. You will be charged for the evaluation regardless of whether you continue as a client.

____Treatment is a Process.

Treatment takes time and many medications require days or weeks to become effective. Furthermore, not all medications work for all people. It is your obligation to keep your provider informed of your progress and medication reactions.

____Phone Calls

Voicemails are checked Monday-Wednesday between 9:00 a.m. and 4:00 p.m. Voicemails will be returned within two business days. Please do not use voicemail as a resource if you are experiencing an emergency or are otherwise in a crisis. Instead, call 911 or go to an emergency room.

____Client Portal & Email Communication

• Email- To be used for issues related to scheduling/administrative matters only. We will not and you should not transmit protected health information (PHI) through email.
• Client Portal- Any communication containing protected health information (PHI) should be sent via the client portal. The portal should only be used for non-emergent clinical matters. Portal messages will be returned within two business days. Not all matters can be resolved via the portal. Your provider may request an appointment or phone call to discuss a clinical matter.
• If PHI is transmitted, it is your responsibility to protect it.

____No Show/Late Policy

A minimum of 24 hours' notice is required for cancellation of all appointments. If you miss your appointment without canceling or cancel less than 24 hours in advance, you may be charged the full amount of the appointment. This includes the initial appointment. You are responsible for remembering your appointment date and time. If a working email/phone number is on file and you elect to receive reminders, automated reminders may be sent but should not be

solely relied upon for scheduling. More than three missed appointments within 12 months may result in discharge from the practice.

_____Paperwork/Letters All forms
Letters, or other paperwork that takes over 15 minutes to complete will be billed based on the time required, in accordance with the applicable hourly rate. Paperwork can take up to 10 business days to complete. Note: We do not complete Social Security Disability Insurance (SSDI) or Emotional Support Animal (ESA) paperwork/letters.

_____Prescription Refills
Refill requests may take up to two business days to complete. There is no separate charge for refill requests made during regular business hours. However, a fee will be charged for 1) urgent refill requests made outside of business hours (Monday-Friday 9am-5pm) including weekends and holidays or 2) refill requests made when a client has not scheduled/attended a followup appointment and needs medication to get through until the next available appointment.

_____Emergency Coverage
We do not provide care outside of regular business hours (MondayWednesday 9am-5pm). Furthermore, we are not equipped to provide crisis care. Clients experiencing any medical or psychiatric emergencies should call 911 or go to their nearest emergency room.

_____Vacation
Because this is a small practice, there is no coverage at this time for vacation. Another provider may or may not provide vacation coverage for non-emergency questions/concerns during regular business hours (Monday- Wednesday, 9am-5pm). ADHD/stimulant or other controlled medication refills may not be available during your provider's vacation period.

_____Medical Records/Documentation
All communication and clinical treatment will be documented in the client chart. You are entitled to receive a copy of these records if you make such a request. If you or your current provider feel that seeing your records would be harmful to you or your treatment, we will be happy to provide a treatment summary instead. We will release records to other members of your healthcare team once a completed and signed Consent for Release of Confidential Information form is submitted via fax, mail, scanned or in person. Electronic requests via email or text will not be accepted.

_____Confidentiality
Your care with Monarch is private and we will protect confidentiality except in narrow circumstances. Specifically, there is no guarantee of confidentiality under the following conditions:

• If your provider suspects you are in imminent danger of harm to self or others. Your provider may be required to take protective action including notifying the potential victim, contacting the police, or seeking hospitalization.
• If a court order or a proper subpoena requires a release of information.
• If you initiate a malpractice lawsuit or a billing dispute with a financial institution.
• If your insurance company requests to review your case (i.e., related to a medication prior authorization).
• If you pay by credit card, our practice name may appear on your credit card statement.
• Between providers and administrative staff, or colleagues with whom our providers consult professionally. Provider communication and collaboration within Monarch is part of the care team approach. If you do not want providers to communicate within the practice, you will need to state this.

_____Telehealth Appointments
We offer appointments utilizing a confidential, HIPAA compliant video platform. There may be circumstances when an in-person appointment is required based on the medication being prescribed (i.e., psychostimulant medication).

_____Controlled Substance Prescription Policy
It is up to the prescriber to determine if a controlled substance should be prescribed, and it is not guaranteed any controlled substances will be prescribed. The Virginia Prescription Monitoring Program (PMP) is used to obtain client prescription histories.
• Controlled Substance Agreement is required in the event controlled substances are prescribed. Clients will be required to sign annually.

• Refills and Replacement – You are responsible for your medication. If any medication is lost or stolen, early refills may not be given. The Provider reserves the right not to prescribe this medication again.
• Abuse / misuse - If at any time it is determined that you are not taking prescribed controlled substance medications as directed, Monarch reserves the right to discharge you, refer you to a substance abuse/detox clinic, and not refill the medication. We are not required to give any additional supply of or prescription for medication in the case of misuse.
• Drug testing – All clients that take controlled substances must be willing to take random drug tests. You may be required to go to LabCorp for a formal drug screen of hair, urine, or blood within 24 hours of a request. If non-compliant, we reserve the right to issue a discharge without medication refill.
• Failure to Disclose/Failed Drug Test – If you test positive for a substance (over-the-counter, legal, or illegal) that has potential for abuse that was not previously disclosed, you may be discharged without medication refill.

_____Non-Voluntary Discharge Policy
A non-voluntary discharge may be given at any time via a mailed termination letter as permitted by applicable law. Some reasons for termination are as follows but are not limited to: 1) Non-compliance with treatment, 2) Violence/perceived threat of violence, physical or verbal intimidation, abuse to any staff, clients, persons including family or friends associated with Monarch. If necessary, local law enforcement may be contacted.

_____Agreement to Terms.
By using our Services, you agree to be bound by these Terms. You agree that any questions have been answered to your satisfaction. If you do not agree to be bound by these Terms, do not use the Services.

Signature: _____ Print: _____ Date: _____

Signature of Parent/Guardian:_____Print: _____Date:_____

MONARCH MENTAL
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Release of Information Authorization _____ I do not wish to release information to anyone but myself

Client Name: _____ Client DOB: _____

Parent/Guardian Name: _____ Parent DOB: _____

Client authorizes Monarch Mental Health and Wellness to disclose the selected information to the following people:

1. Name: _____ Phone: _____ Relationship: _____
2. Name: _____ Phone: _____ Relationship: _____
3. Name: _____ Phone: _____ Relationship: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED

____Assessment ____Diagnosis ____Psychological Evaluation ____Progress in Treatment
____Current Treatment Update
__Present/Participation in Treatment to include appointment dates and times
____Other_____

REVOCATION: I understand that I have a right to revoke this authorization, in writing, at any time by sending a written notification to Monarch Mental Health and Wellness administration at frontdesk@monarchmentalwellness.com I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

EXPIRATION: Unless sooner revoked, this authorization does not expire.

FORM OF DISCLOSURE: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we deem appropriate and consistent with applicable law and our Privacy Policy, including, but not limited to, verbally, in paper format, and electronically.

REDISCLOSURE: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Signature: _____ Print: _____ Date: _____

Signature of Parent/Guardian:_____Print: _____Date:_____

MONARCH MENTAL
HEALTH AND WELLNESS

Phone & Email Contact Consent and Authorization

I, _____ , with respect to any services provided or that are planned to be provided to myself or, as an authorized legal representative, for the below listed individual, fully consent to and authorize Monarch Mental Health and Wellness staff and providers or any of its automated systems to contact me via phone or email address (including to my cellular phone by way of phone call, or text message) in relation to any services received from Healthcare Provider or any services planned to be received from Healthcare Provider (including any billing items or appointment reminders).

As a patient of Monarch Mental Health and Wellness you may request that we communicate with you via unencrypted electronic mail (email). This page will inform you of the risks of communicating with your healthcare provider via email. Your health is important to us and we will make every effort to reasonably comply with your request to receive communications via email, however, we reserve the right to deny any request for email communications when it is determined that granting such a request would not be in your best interest.

Monarch Mental Health and Wellness will make every effort to promptly respond to your requests for information via email, however, *if you are experiencing an emergency, you should never rely on email communications and should seek immediate medical attention*.

Patient Consent to Unencrypted Email Communications

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into the medical record at the provider's discretion.

By signing below, you also acknowledge that you have the choice to receive communications via other more secure means such as by telephone. By signing below, you agree to hold Monarch Mental Health and Wellness harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address you provide.

If this Consent and Authorization *applies to someone for whom you are a legal representative, **please print their name below**, if not please indicate so by populating the blank with N/A*.

Signature: _____ Print: _____ Date: _____

Signature of Parent/Guardian:_____Print: _____Date:_____

MONARCH MENTAL
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Telehealth Consent Form

Patient Name: _____ Date of Birth:_____

1. I understand that my provider wishes me to engage in a telemedicine visit.
2. My provider has explained to me how the video conferencing technology will be used and how it will not be the same as a direct patient visit.
3. I understand there are potential flaws to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. The information shared will only be on a need to know basis explicitly for billing and scheduling.
5. I have had the alternatives to a telemedicine explained to me, and am choosing to participate in a telemedicine visit.
6. I understand that billing will occur from my therapist under the facility of Monarch Mental Health and Wellness.
7. I have had a direct conversation with my provider,, during which I had the opportunity to ask questions in regard to this telemedicine visit. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature: _____ Print: _____ Date: _____

Signature of Parent/Guardian:_____Print: _____Date:_____

MONARCH MENTAL
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CONTROLLED SUBSTANCES AGREEMENT

The purpose of this Agreement is to prevent misunderstandings regarding controlled substances that you may be prescribed by the providers at this clinic. The goal is to treat you safely with these potent medications and also to prevent abuse of or addiction to these medications. This Agreement is also set forth to assist you and your provider to comply with the law regarding controlled substances.

Because these medications have the potential for abuse or diversion, strict accountability is necessary for both medical safety and legal reasons. Therefore, the following policies are agreed to by you, the client, to help maintain safety and provide quality, effective care.

I agree to the following:

- I am responsible for my medications. I will not share, sell or trade my medication. I will not take anyone else's medication.
- I will not increase my medication unless I speak with my provider. If I do so on my own, my provider may taper or discontinue my medication. Use of medication at a greater rate than prescribed may result in my being without medication for a period of time.
- My medication may not be replaced if it is lost, stolen or consumed earlier than prescribed. My prescription for a controlled substance may not be replaced if lost/stolen.
- Renewals are contingent on keeping scheduled appointments. I will not phone/text for prescriptions after hours or on weekends. Early refills will not be given.
- I agree to voluntary urine drug testing for controlled substances before initiation of therapy and that random urine follow-up testing may be done even if not covered by my insurance. If there is a presence of unauthorized substances, illicit substances or absence of prescribed medications, I may be referred for assessment for addiction disorder and possibly tapered and discontinued from the controlled substance immediately or in the future.
- I will exercise extreme caution when taking these medications and driving or operating heavy machinery. The use of these medications may induce drowsiness or change your mental abilities, thereby making it unsafe to drive or operate heavy machinery.
- I will not obtain any controlled medications, including benzodiazepines, controlled stimulants or anti-anxiety medications to treat the same symptoms from any other doctor.
- I will not take any illegal drugs.

You must obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, our office must be informed.

The pharmacy that you have selected is: _____

Address: _____ Phone #___

I understand that if I break this agreement, my provider may stop prescribing me certain medications and/or release me from the practice. I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding this agreement have been adequately answered.

Client Name:_____ DOB: _____ Client Signature: _____ Date:_____

MONARCH MENTAL
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HIPAA Compliance Client Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The Notice contains a client's rights section describing your rights under the law. You agree that by your signature that you have reviewed our Notice before signing this consent.

The terms of the Notice may change, if so, you will be notified at your next visit to update your signature/date.

The **HIPAA** (Health Insurance Portability and Accountability Act of 1996) law allows for certain use and disclosure of the information for treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

By signing this form, you consent to our use and disclosure of your protected healthcare information and anonymous/de-identified usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law. • The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The client has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? _____YES_____ NO

May we leave a message on your answering machine at home or on your cell phone? _____YES _____ NO

May we discuss your medical condition with any member of your family? ____YES _____ NO

If YES, please name the members allowed: _____

Signature: _____ Print: _____ Date: _____