CPHS | Carolina Personalized Health Solutions

POLICIES

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over to Carolina Personalized Health Solutions (CPHS) all my rights, title, and interest to my medical reimbursement benefits under my insurance policy and authorize CPHS to file (and assign to CPHS my right to file) my insurance claim under my policy for services provided by CPHS. I further authorize the release of any medical information needed to determine benefits, including psychiatric, substance abuse (drug or alcohol), psychological, assessment, diagnosis, and treatment information for the routine processing of these claims.

This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not release me of my obligation to pay such bills if not paid by my Insurance Company or of any balance due after payments by my Insurance Company.

CAROLINA PERSONALIZED HEALTH SOLUTIONS FINANCIAL POLICY

First Appointment: Please have your current insurance card available with you. On follow-up visits, you will be asked to verify demographic/insurance information so that our records remain up to date. Please be prepared to pay for the current visit as well as any past balances on your account. Payment of co-pays, deductibles or any non-covered services will be required at the time of service. Paying applicable co-pays/deductibles/co-insurance charges at the time of service does not mean that you will not receive a bill after your visit. Fees are only estimated. For your convenience, we accept CHECKS, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS, AND DEBIT.

Insurance: When scheduling an appointment at our practice, it is your responsibility to confirm with your insurance company that the clinician is under contract with your plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you have the referral in hand at the time of your appointment. If your insurance should happen to change, we require that you notify our office 24 hours prior to your appointment time. If you do not notify us (before the date services are rendered) of any changes in your insurance coverage, **YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.**

Proof of Insurance: . PATIENT MUST PROVIDE CORRECT INSURANCE INFORMATION AT TIME OF SERVICE. FAILURE TO DO SO MAY RESULT IN A $10 REBILLING CHARGE.

CO-PAYS: CO-PAYS ARE DUE AT THE TIME OF SERVICE. A $10 BILLING CHARGE MAY BE ADDED TO COVER BILLING EXPENSES IF NOT PAID AT THE TIME OF SERVICE.

Client is responsible for knowing their benefit coverage for specialist visits. We will be happy to file your insurance claim on your behalf. We allow 45 days from date the claim was filed for your insurance company to pay. If your insurance does **NOT** pay within this time, you may be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and /or policy benefit criteria (e.g., deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions, or reasonable and customary charges, etc.) other than to supply factual information when necessary.

Out-of-Network Insurance & Insurance Denials: If you have insurance our practice does not accept or claim is denied by your insurance company, you will be responsible for the full amount of all professional fees and charges for services provided. We can provide you with a receipt for clinical services rendered that you may submit to your insurance company for reimbursement.

If you are insured by a managed care organization (HMO), and being seen for any covered service, you must have PRIOR AUTHORIZATION**.** If you do not obtain authorization, you will be responsible for PAYMENT IN FULL. We recommend you contact the customer service number on your insurance card prior to your first visit to determine if prior authorization is required and basic information regarding your behavioral health benefits.

Any Preferred Provider (PPO) or In-Network discounts will not apply UNLESS YOU HAVE YOUR INSURANCE CARD WITH YOU**.** If you do not have your insurance card with you, insurance has instructed us to collect payment in full for all services received. If your insurance informs us your eligibility status has changed, you will be responsible for payment in full until verification of insurance benefits is obtained from your insurance carrier.

Usual and Customary Rates: CPHS is committed to providing the best treatment for our clients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

You are responsible for deductibles, co-insurance, non-covered services, and any other charges your insurance may not cover. You will be sent monthly statements regarding any monies owed by you, the client. If the same balance becomes more than 3 months past due, you will be charged a finance charge of $10.00 each month thereafter until the balance is paid in full. If your account must be turned over to a collection agency, all discounts will be removed, and collection processing fees will be added to the account. Additional fees may be added if the account is not paid within 45 days of being placed in collections. Credit bureaus are advised of unpaid debt.

Collections: Accounts will be sent to collections after 90 days if not paid as agreed. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, our practice has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require our

practice, as allowed by law, to disclose confidential information about you. You agree that if we must collect on your account that you will be responsible for the costs of collection, including attorneys' fees. In most collection situations, the only information our practice would release regarding a client's treatment is his/her name, the type of services provided, and the amount due [If such legal action is necessary, these costs will be included in the claim].

An administrative fee of **$42** will be applied for **all returned checks with insufficient funds.**

NO SHOW / LATE CANCELLATION POLICY:
Please be mindful that your appointment time is reserved **exclusively** for you and be considerate of others – if you miss your appointment or cancel at the last minute, we will be unable to provide care for another client in your place and have no way of recovering lost revenue due to "no-shows" or last-minute cancellations.

CPHS charges a *$55 administrative fee for missed appointments or appointments cancelled / rescheduled with less than 24 hours advance notice *(*Note: excludes the following: Aetna EAP, Corp Care EAP, Business Health Services EAP, TriCare North, SC Medicaid, or in the case of severe illness and emergency situations).* This fee is non-refundable and is **not** covered by your insurance or EAP.

I UNDERSTAND THAT I AM RESPONSIBLE FOR FINDING A NEW PROVIDER IF I FAIL TO SHOW UP FOR TWO CONSECUTIVE APPOINTMENTS or MULTIPLE NO SHOWS, WITHOUT PROVIDING A 24 HOUR NOTICE. WE WILL NOT CONTINUE TO PROVIDE SERVICE AFTER TWO NO-SHOWS. I HAVE READ AND AGREE TO THE ABOVE POLICY TERMS.

Administrative Fees: Like other medical practices, declining insurance reimbursements and rising costs force us to charge for certain administrative services that are not covered by insurance. The following fees are applicable to all patients and are **not covered by insurance or EAPs** in which patient shall be solely responsible:

REVIEW OF PSYCHOLOGICAL / MEDICAL FORMS / LEGAL FORMS / COURT DOCUMENTS / REPORTS, & LETTER COMPLETION (COMPLETED OUTSIDE OF APPOINTMENT TIMES)

• $50 minimum [pro-rated at $25 / 15 minutes to complete thereafter] **NON-CRISIS TELEPHONE CONSULT / AFTER-HOURS CONSULT WITH CLINICIAN**

• $50 minimum [Pro-Rated at $25 / 15 minutes thereafter] **E-MAIL CONSULT WITH CLINICIAN**

Thank you for understanding the reason behind these fees. We will be reasonable in applying them and notify you when they apply.

CONSENT FOR E-MAIL AND ELECTRONIC MEANS OF COMMUNICATION

As a covered entity under the HIPAA Privacy and Security Rules, we take your privacy and right for confidentiality seriously. Although convenient, email and other forms of electronic

communication are not a secure medium because third parties can view and store confidential information. Therefore, email and other forms of electronic communication are *not* to be considered completely confidential forms of communication, and using email runs the risk of breaching your confidentiality.

RISKS OF USING E-MAIL & OTHER FORMS OF ELECTRONIC COMMUNICATION TO COMMUNICATE WITH CAROLINA PERSONALIZED HEALTH SOLUTIONS
Transmitting client information by e-mail has a number of risks that need to be considered before using e-mail to communicate with your provider. These include, but are not limited to, the following risks:

• E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
• E-mail can be immediately broadcast worldwide and be received by unintended recipients.
• E-mail senders can easily type in the wrong email address.
• E-mail is easier to falsify than handwritten or signed documents.
• Backup copies or e-mail may exist even after sender or recipient has deleted their copy.
• Employers and on-line services have a right to archive & inspect e-mails transmitted through their systems.
• E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
• E-Mail can be used to introduce viruses into computer systems.
• E-mail can be used as evidence in court.

TYPES OF PERMISSIBLE E-MAIL OR ELECTRONIC COMMUNICATION THAT CLIENT AGREES TO SEND AND/OR RECEIVE includes:

- Appointment scheduling requests and appointment reminders.
- Billing and insurance questions and patient education
- Use of e-mail for general client information only

If you are an active client of CPHS and experiencing an urgent, clinical emergency and the office is closed, you may reach the **on-call provider at (803) 784-4429.** Please leave your name, telephone number and a brief message so that the on-call clinician can assist you. For all other **non-urgent concerns, please contact the office at (803) 784-4429**. Our office hours are 8 am – 5 pm, Monday through Thursday and 8 am – 2 pm Friday or please leave us a voice mail message.

f you feel that you have a **life-threatening emergency, call 911 or go to the nearest emergency room**. In addition, contact the **National Suicide Prevention Hotline # 1-800-273-8255 or 1-800-784 2433** to be connected to a skilled, trained counselor at a crisis center 24/7.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT I acknowledge that CPHS's staff and practice administrative staff will not accept friend or contact requests from current or former client's social networking site (e.g., Facebook, LinkedIn, etc.). I understand that adding current or

former practice staff as friends or contacts can compromise my confidentiality and respective privacy.

I have had the opportunity to discuss the above and acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the therapist and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that the therapist may impose to communicate with patients by e-mail. Any questions I may have had were answered.

CPHS TELEHEALTH INFORMED CONSENT

Introduction of TeleHealth:

As a client or patient receiving services at CAROLINA PERSONALIZED HEALTH SOLUTIONS telehealth technologies, I understand:

TeleHealth is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location.

IMPORTANT: To receive Telehealth services at CPHS, client must have a valid, credit card on-file to pay for all applicable copay/session fees [note: credit card information is securely stored with CPHS'S credit card processor via PCI-compliant, encrypted vault] or Client must Pre-Pay for all applicable copay/fees prior to Telehealth session.

The interactive technologies used in telehealth incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Software Security Protocols:

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

Benefits & Limitations:

This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. There are benefits and limitations to this service.

Technology Requirements:

I will need access to, and familiarity with, the appropriate technology to participate in the service provided.

Exchange of Information:

The exchange of information will not be direct, and any paperwork exchanged will likely be provided through electronic means or through postal delivery.

During my telehealth *consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals using interactive video, audio or other telecommunications technolog*y.

Local Providers:

If a need for direct, in-person services arises, it is my responsibility to contact providers in my area or to contact my behavioral provider's office for an in-person appointment or my primary care physician if my behavioral provider is unavailable. I understand that an opening may not be immediately available in either office.

Self-Termination:

I may decline any telehealth services at any time without jeopardizing my access to future care, services, and benefits.

Risks of Technology:

These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Modification Plan:

My provider and I will regularly reassess the appropriateness of continuing to deliver services to me using the technologies we have agreed upon today, and modify our plan as needed.

Emergency Protocol:

In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:

Disruption of Service:
Should service be disrupted; we will try to utilize alternative for other means of communication.

Provider Communication:
Your provider may utilize alternative means of communication if circumstances should arise.

Your provider will typically respond to communications and routine messages within 24 – 48 hours.

Client Communication:
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.

I will take precautions to ensure that my communications are directed only to my provider or other designated individuals.

Client's Electronic Medical Record. Laws & Standards:

The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

ADDENDUM A – ELECTRONIC TRANSMISSION OF INFORMATION:

I, the undersigned, agree to participate in technology-based consultation and other healthcare-related information exchanges with CAROLINA PERSONALIZED HEALTH SOLUTIONS, a behavioral health care provider ("provider"). This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named provider, other persons involved in my health care, and the staff operating the consultation equipment.

Mobile Application:

It may also mean that my private health information may be transmitted from my provider's mobile device to my own or from my device to that of my provider via an "application" (abbreviated as "app").

I understand that a variety of alternative methods of behavioral health care may be available to me, and that I may choose one or more of these at any time. My behavioral health care provider has explained the alternative to my satisfaction.

Equipment:

I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I am aware that any

information I enter an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

Identification:

I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access.

Telehealth Process:

My health care provider has explained how the telehealth consultation(s) is performed and how it will be used for my treatment. My behavioral provider has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

Additional Services:
I understand that it is my duty to inform my provider *of electronic interactions regarding my care that I may have with other health care providers.*

Electronic Presence:

In brief, I understand that my provider will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter an "app" will be transmitted electronically to and from myself and my provider.

Limitations:

Regardless of the sophistication of today's technology, some information my provider would ordinarily get in an in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my provider to understand my problems and to help me get better. My provider will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

Risks:

I understand that telehealth is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, including some that are not yet recognized.

Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons.

In rare instances, security protocols could fail, causing a breach of privacy of personal health information. I understand that a physical examination may be performed by individuals at my location at the request of the consulting provider.

Release of Information:

I authorize the release of any information pertaining to me determined by my provider, my other health care providers or by my insurance carrier to be relevant to the consultation(s)or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

Discontinuing Care:

I understand that at any time, the consultation(s) can be discontinued either by me or by my designee or by my health care providers.

I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and that no action will be taken against me.

I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly.

Were that to happen, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

Limits of Confidentiality:

I also understand that, under the law, and regardless of what form of communication I use in working with my provider, my provider may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others.

Alternatives:

The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person consultations. I understand that the telehealth consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telehealth consultation’s effectiveness.

Records:

I understand that my telehealth consultation(s) may be recorded and stored electronically as part of my medical records. I understand that consultations, test results, and disclosures will be held in confidence subject to state and/or federal law. I understand that I am ordinarily guaranteed access to my records and that copies of records of consultation(s) are available to me on my written request.

I also understand, however, that if my provider, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy.

Additionally, I understand that my records may be used for telehealth program evaluation, education, and research and that I will not be personally identified if such use occurs. I hereby authorize these disclosures to take place without prior written consent.

Compensation:

I understand that I am not entitled to royalties or to other forms of compensation for participation in any telehealth consultation(s) or other information exchange.

Contact Information:

I have received a copy of my provider's contact information, including their name, telephone number, pager and/or voice mail number, mailing address, and e-mail address (if applicable). I have also been provided with a list of local support services in case of an emergency. I am aware that my provider may contact the proper authorities and/or my designated, local contact person in case of an emergency.

Emergency Care:

I acknowledge, however, that if I am facing or if I think I may be facing an emergency that could result in harm to me or to another person; I am not to seek a telehealth consultation. Instead, I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.

Release of Liability:

I unconditionally release and discharge Carolina Personalized Health Solutions, its affiliates, agents, employees; and my provider and his or her designees from any liability in connection with my participation in remote telehealth consultation(s).

Final Agreement:

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers.

With this knowledge, I voluntarily consent to participate in the telehealth consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.