New Patient Intake Form: Demographics and Patient Information

Are you filling this form out on behalf of yourself or someone else? ☐ Myself ☐ Someone Else

If "Someone Else" what is your relationship with the patient?

☐ Parent ☐ Guardian ☐ Other: _____

Your Legal Name: First: _____ MI: _____ Last: _____

Your Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: Cell: _____ Work: _____ Other: _____

Email: _____

Patient Demographic Information

Patient Legal Name: First: _____ MI: _____ Last: _____ Suffix: __

Patient Preferred Name: _____

Date of Birth: ___/___/_____ Height: _____ Weight: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: Cell: _____ Work: _____ Other: _____

Email: _____

Gender Assigned at Birth: ☐ Female ☐ Male

Preferred Gender: ☐ Nonbinary ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male

☐ Other: _____ ☐ Prefer not to answer

Preferred Pronouns: ☐ She/Her/Hers ☐He/Him/His ☐ They/Them/Theirs ☐ Other: _____

Ethnicity

☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Caucasian

☐ Multi-Ethnic ☐ Native Hawaiian/Pacific Islander ☐Other ☐ Hispanic/Latino

☐ Prefer not to answer

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ In a Relationship

☐ Other _____

Highest Level of Education: _____ Occupation: _____

Is the patient currently on disability or SSI? ☐ No ☐ Yes If "Yes" please specify: _____

Payor Information

Please check one: ☐ Self-Pay/Uninsured ☐ Using Insurance

If you are self-pay, you are entitled to a good faith estimate of the costs for your appointment.

If using insurance, please fill in the following section completely. Please provide insurance card and photo identification.

Insurance Company Name: _____ Phone: _____

Member ID#: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship to the Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Is the Payer an Employee Assistance Program: ☐ No ☐ Yes

If "Yes," Company Name: _____

Authorization Number: _____

Effective Date: _____

bloom health centers

Purpose of Appointment and Medical History

Please briefly describe the purpose of your appointment:

_____

_____

_____

Allergies (including allergies to medications):

_____

_____

Current Medications:

If you are currently on a controlled substance medication and need to refill the medication, you will have to see the provider in-person prior to getting the refill. If you do not see the provider in-person, the pharmacy may not dispense the medication.

Medication	Dose/Strength	Times Per Day

Substance Use

Do currently or previously use substances? ☐ Yes ☐ No ☐ Will disclose with provider

If "Yes" please list illicit or non-illicit substances used, frequency, and last date used:

_____

_____

Current Symptoms

Please list current symptoms related to the problem for which you are seeking help. This may include depressed mood, decreased concentration or energy level, anxiety, disruptive eating habits, impulsivity, or other behaviors or emotions that are impacting your daily life.

_____

_____

Medical History

Do you have or ever have had the following conditions? Please select all that apply.

☐ Anemia	☐ Dissociation	☐ IBS	☐ Pneumonia
☐ Angina	☐ Eating disorder	☐ Kidney Disease	☐ Psoriasis
☐ Anxiety	☐ Emphysema	☐ Leukemia	☐ Psychosis
☐ Asthma	☐ Fibromyalgia	☐ Liver disease	☐ Seizures
☐ Bipolar affective disorder	☐ Goiter	☐ Lupus	☐ Schizophrenia
☐ Cancer	☐ Heart murmur	☐ Migraines	☐ Stomach Ulcers

☐ Colitis	☐ Heart disease	☐ Multiple Sclerosis	☐ Stroke
☐ Chron's Disease	☐ High blood pressure	☐ OCD	☐ Surgery
☐ Depression	☐ High cholesterol	☐ Paranoia	☐ Thyroid dysfunction
☐ Diabetes	☐ HIV/AIDS	☐ Post-traumatic stress disorder	☐ Traumatic brain injury
			☐ Tuberculosis

Other medical conditions not listed above: _____

_____

Psychiatric History
Please list any previous psychiatric history, including mental health treatment and providers, medications, and dates of treatment if possible.

_____

_____

Have you been previously hospitalized for a mental health concern, including but not limited to attempted suicide, anxiety attack, panic attack, or other psychotic episode? ☐ Yes ☐ No

If "Yes" where were you seen? _____ Phone: _____

Approximate date: _____

Please describe: _____

_____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

Pharmacy

Name: _____

Address: _____

Phone: _____ Fax: _____

New Patient Intake Form: Patient Rights

As a patient of Bloom Health Centers (BHC) you have certain rights. Please review the following information carefully. If you have any questions, please don't hesitate to contact us at 667-668-2566 or info@bloomhealthcenters.com.

No Surprises Act Right to a Good Faith Estimate

If you are a self-pay patient, or choose to self-pay for services, you must let us know. You have a right to a Good Faith Estimate (GFE) under the No Surprises Act which will outline the estimated charges that are reasonably expected for your health care needs for an item or service. The estimate is based on the information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, and your bill is $400 or more for any provider or facility than your GFE for that provider or facility, federal law allows you to dispute the bill.

If you are billed for more than this Good Faith Estimate, you may have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the GFE. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

☐ I have read and understand the above

Signature:

_____

Date:

_____

Notice of Privacy Practices

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

Psych Associates Group, LLC/Psych Associates of Maryland, LLC dba Bloom Health Centers
1954 Greenspring Drive, Suite 530
Timonium, MD 21093
Bloomhealthcenters.com
Privacy Contact Phone Number: 667-668-2566
Privacy Contact email address: info@bloomhealthcenters.com

Effective date: April 12, 2022

Summary
This is a summary of how we may use and disclose your protected health information and your rights and choices when it comes to your information. We will explain these in more detail below.

Our Uses and Disclosures
We may use and disclose your information as we:

- Treat you.
- Bill for services.
- Run our organization.
- Do research.
- Comply with the law.
- Respond to organ and tissue donation requests.
- Work with a medical examiner or funeral director.
- Address workers' compensation, law enforcement, or other government requests.
- Respond to lawsuits and legal actions.

Your Choices
You have some choices about how we use and share information as we:

- Communicate with you.
- Tell family and friends about your condition.
- Provide mental health care.
- Market our services.

Your Rights
You have the right to:

- Get a copy of your paper or electronic protected health information.
- Correct your protected health information.
- Ask us to limit the information we share, in some cases.
- Get a list of those with whom we've shared your information.

- Request confidential communication.
- Get a copy of this privacy notice.
- Choose someone to act for you.
- File a complaint if you believe we have violated your privacy rights.

Purpose

Bloom Health Centers (Bloom or We) respects your privacy. We are also legally required to maintain the privacy of your protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.

As part of our commitment and legal compliance, we are providing you with this Notice of Privacy Practices (Notice). This Notice describes:

- Our legal duties and privacy practices regarding your PHI, including our duty to notify you following a data breach of your unsecured PHI.
- Our permitted uses and disclosures of your PHI.
- Your rights regarding your PHI.

Contact

If you have any questions about this Notice, please contact:

Bloom Compliance Department
1954 Greenspring Drive, Suite 530
Timonium, MD 21093
Phone: 667-668-2566
Email: compliance@bloomhealthcenters.com

PHI Defined

Your PHI:

- Is health information about you:
  - which someone may use to identify you; and
  - which we keep or transmit in electronic, oral, or written form.
- Includes information such as your:
  - name;
  - contact information;
  - past, present, or future physical or mental health or medical conditions;
  - payment for health care products or services; or
  - prescriptions.

Scope

We create a record of the care and health services you receive, to provide your care, and to comply with certain legal requirements. This Notice applies to all the PHI that we generate. We follow and our employees and other workforce members follow the duties and privacy practices that this Notice describes and any changes once they take effect.

Changes to this Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new notice will be available on request, in our office, and on our website.

Data Breach Notification

We will promptly notify you if a data breach occurs that may have compromised the privacy or security of your PHI. Most of the time, we will notify you in writing, by first-class mail, or we may email you if you have provided us with your current email address and you have previously agreed to receive notices electronically. In some circumstances, our business associates, which are described in more detail below, may provide the notification. In limited circumstances when we have insufficient or out-of-date contact information, we may provide notice in a legally acceptable alternative form.

Uses and Disclosures of Your PHI

The law permits or requires us to use or disclose your PHI for various reasons, which we explain in this Notice. We have included some examples, but we have not listed every permissible use or disclosure. When using or disclosing PHI or requesting your PHI from another source, we will make reasonable efforts to limit our use, disclosure, or request about your PHI to the minimum we need to accomplish our intended purpose.

Uses and Disclosures for Treatment, Payment, or Health Care Operations

- Treatment. We may use or disclose your PHI and share it with other professionals who are treating you, including doctors, nurses, technicians, medical students, or hospital personnel involved in your care. For example, we might disclose information about your overall health condition to physicians who are treating you for a specific injury or condition.
- Payment. We may use and disclose your PHI to bill and get payment from health plans or others. For example, we share your PHI with your health insurance plan so it will pay for the services you receive.
- Health Care Operations. We may use and disclose your PHI to run our practice and improve your care. For example, we may use your PHI to manage the services you receive or to monitor the quality of our health care services.

Other Uses and Disclosures

We may share your information in other ways, usually for public health or research purposes or to contribute to the public good. For more information on permitted uses and disclosures, see https://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. For example, these other uses and disclosures may involve:

- Our Business Associates. We may use and disclose your PHI to outside persons or entities that perform services on our behalf, such as auditing, legal, or transcription (Business Associates). The law requires our business associates and their subcontractors to protect your PHI in the same way we do. We also contractually require these parties to use and disclose your PHI only as permitted and to appropriately safeguard your PHI.
- Legal Compliance. For example, we will share your PHI if the Department of Health and Human Services requires it when investigating our compliance with privacy laws.
- Public Health and Safety Activities. For example, we may share your PHI to:
    - report injuries, births, and deaths;
    - prevent disease;

- report adverse reactions to medications or medical device product defects;
- report suspected child neglect or abuse, or domestic violence; or
- avert a serious threat to public health or safety.

- Responding to Legal Actions. For example, we may share your PHI to respond to:
  - a court or administrative order or subpoena;
  - discovery request; or
  - another lawful process.
- Research. For example, we may share your PHI for some types of health research that do not require your authorization, such as if an institutional review board (IRB) has waived the written authorization requirement because the disclosure only involves minimal privacy risks.
- Medical Examiners or Funeral Directors. For example, we may share PHI with coroners, medical examiners, or funeral directors when an individual dies.
- Workers' Compensation, Law Enforcement, or Other Government Requests. For example, we may use and disclose your PHI for:
  - workers' compensation claims;
  - health oversight activities by federal or state agencies;
  - law enforcement purposes or with a law enforcement official; or
  - specialized government functions, such as military and veterans' activities, national security and intelligence, presidential protective services, or medical suitability.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, please contact the Bloom Compliance Department and we will make reasonable efforts to follow your instructions.

- You have both the right and choice to tell us whether to:
  - Share information, such as your PHI, general condition, or location, with your family, close friends, or others involved in your care.
- We may share your information if we believe it is in your best interest, according to our best judgment, and:
  - If you are unable to tell us your preference, for example, if you are unconscious.
  - When needed to lessen a serious and imminent threat to health or safety.

Uses and Disclosures that Require Authorization

In these cases we will only share your information if you give us written permission:

- Most sharing of a mental health care professional's notes (psychotherapy notes) from a private counseling session or a group, joint, or family counseling session.
- Marketing our services.
- Selling or otherwise receiving compensation for disclosing your PHI.
- Certain research activities.
- Other uses and disclosures not described in this Notice.

You may revoke your authorization at any time, but it will not affect information that we already used and disclosed.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

You have the right to:

- Inspect and Obtain a Copy of Your PHI. You have the right to see or obtain an electronic or paper copy of the PHI that we maintain about you (right to request access). Some clarifications about your access rights:
    - we may require you to make access requests in writing by submitting an electronically signed form to the Bloom Compliance Department;
    - we may charge a reasonable, cost-based fee for the costs of copying, mailing, or other supplies associated with your request.
    - we may deny your request for access in certain limited circumstances, however, if we deny your access request, we will provide a written denial with the basis for our decision and explain your rights to appeal or file a complaint.
- Make Amendments. You may ask us to correct or amend PHI that we maintain about you that you think is incorrect or inaccurate. For these requests:
    - you must submit requests electronically, specify the inaccurate or incorrect PHI, and provide a reason that supports your request.
- Request Additional Restrictions. You have the right to ask us to limit what we use or share about your PHI (right to request restrictions). You can contact us and request us not to use or share certain PHI for treatment, payment, or operations or with certain persons involved in your care. We require that you submit this request in writing. For these requests:
    - we are not required to agree;
    - we may say "no" if it would affect your care; but
    - we will agree not to disclose information to a health plan for purposes of payment or health care operations if the requested restriction concerns a health care item or service for which you or another person, other than the health plan, paid in full out-of-pocket, unless it is otherwise required by law.
- Request an Accounting of Disclosures. You have the right to request an accounting of certain PHI disclosures that we have made. For these requests:
    - we will respond no later than 60 days after receiving the request. We may ask for an additional 30 days during this 60-day period, but if we do, we will only do it once, provide a written statement of why, and indicate the date by which we intend to send the response;
    - we will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures, such as any you asked us to make; and
    - we will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months. We will notify you about the costs in advance and you may choose to withdraw or modify your request at that time.
- Choose Someone to Act for You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your PHI. We will confirm the person has this authority and can act for you before we take any action.

- Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or at a specific address. For these requests:
    - you must specify how or where you wish to be contacted; and
    - we will accommodate reasonable requests.
- Make Complaints. You have the right to complain if you feel we have violated your rights. We will not retaliate against you for filing a complaint. You may either file a complaint:
    - directly with us by contacting Bloom Compliance Department at the address provided above. All complaints must be submitted in writing; or
    - the US Department of Health and Human Services.

Patient Responsibilities

Bloom Health Centers strives to provide high-quality, evidence-based mental health services. In order to do so, we have outlined your rights. For us to best serve you, you have responsibilities as a patient of our practice. Please read the following carefully. You may contact us with questions or concerns at info@bloomhealthcenters.com.

Patient and Provider Privacy

For the protection of our patients, providers, and staff, any activity that may be considered an invasion of privacy while in our offices or during the provision of services will result in the offender being discharged from our practice. These activities include, but are not limited to, photography, recording conversations, or similar behavior. The offender will be prosecuted under the fullest extent of the law.

☐ I have read and understand the above

Signature: _____

Date: _____

Financial Policy

We accept some credit cards, and checks with a valid driver's license. If your insurance policy requires preauthorization for a service and you do not have that authorization, you will be responsible for payment of the full fee at the time of service. If your insurance denies a claim because there is no initial authorization, you are responsible for payment of the entire fee. Payment of copay is expected at the time of service. In the event that your account becomes delinquent and is forwarded to an attorney for collection, the patient is responsible for the attorney fees and all court costs.

Because of our contracts with insurance companies, we are unable to provide service without charging you your financial responsibility under your insurance plan. You are authorizing BHC to bill your insurance company directly and receive compensation for services rendered. You are authorizing BHC to send treatment plans to your insurance company and exchange information when it pertains to payment of the treatment you receive.

If you provide credit card information, you are authorizing BHC to charge your credit card for services rendered. Cards on file may be used to make payments on outstanding balances.

All overpayments are credited to your account. They will be held and applied as needed until all services have been paid in full. Remaining overpayments will be applied against future services, unless the overpayment is at least $20.00 and you request reimbursement.

If you are uninsured, we will bill you based on our self-pay rates. You have a right to request a Good Faith Estimate of the charges prior to your appointment.

☐ I have read and understand the above

Signature: _____

Date: _____

Missed and Late Appointments

Mental health resources are very limited, so Bloom Health Centers (BHC) attempts to ensure that appointments are available for those who need them. Therefore, it is our practice to deter 'no-showing' or canceling appointments without sufficient time to offer the appointment to another patient. Patients who no-show or who cancel their appointment less than one business day in advance will be charged the $100.00 no-show fee. An appointment will be considered a no-show if the patient has not appeared after ten minutes into the scheduled appointment time. Patients may request to appeal the fee by contacting BHC at 667-668-2566.

☐ I have read and understand the above

Signature: _____

Date: _____

Medication Refill Requests

Please be sure to schedule appointments within enough time to refill your medications. Refill requests will not be authorized without seeing your provider. It is up to the provider's discretion to provide a bridge refill based on the type of medication and the care plan. If a bridge refill is approved and needed due to a cancellation that was not initiated by the provider, there will be a $15.00 bridge refill charge that must be paid prior to the provider completing the request.

☐ I have read and understand the above

Signature: _____

Date: _____

Controlled Substance Use Agreement

Bloom Health Centers (BHC) providers follow clinical guidelines to ensure that each medication you take is safe, beneficial, and appropriate for your circumstances. In order to be prescribed controlled substances, you must read and agree to the following requirements.

- The decision to prescribe controlled substances is up to my provider's clinical judgement. My provider may cease treatment with controlled substance medications, adjust my dose, or taper me off the medication at their discretion. I understand that my provider is under no obligation to provide these prescriptions and that they reserve the right to discontinue these medications at any time.

I will take the medication only as prescribed. I will discuss controlled substances I am prescribed from other providers with my BHC provider so that my BHC provider may ensure the medications I am on are safe and clinically appropriate.

- I understand that I may need to see my provider in-person to be prescribed controlled substances. This is a legal requirement and if it is not met, the pharmacy may not dispense my medications.
- I will not receive the same controlled substance from multiple providers. If I receive a controlled substance prescription from a BHC provider, I will not obtain the same medication from a different provider.
- My BHC provider may contact my other healthcare providers to review my current medications and treatment plans in accordance with applicable laws and regulations.
- I understand that the medication will be prescribed only according to the agreed-upon schedule. Prescriptions will be provided only during regular business hours.
- Medication refills will be provided as electronic prescriptions only.
- I understand that I must make appointments with my provider at the frequency that my provider recommends.
- Being present to appointments is important for my health and safety. I understand that repeated no-show appointments may constitute grounds for discharge.
- It is my responsibility to protect and secure my medications. This includes keeping the medication out of reach of children. If my controlled substance prescription or medication is lost or stolen, a copy of a police report is required in order to be considered for a refill.
- I understand that my provider may request specialist evaluation of my treatment and I agree to attend the appointments. My provider will send a copy of my medical record and care to the referred provider.
- My provider may require me to undergo a random urine sample. I will complete these tests within the specified timeframe.
- I understand that my provider is required by law to report all controlled substances dispensed to me to the state's mandated prescription monitoring program.

☐ I have read and understand the above

Signature: _____

Date: _____

Telehealth Consent

Telehealth in General: Telehealth involves real-time evaluation, diagnosis, consultation, and treatment of a health care condition using telecommunications technology, including interactive audio and video. Electronic systems used have network and software security protocols in place to protect the confidentiality of patients' information.

Expected Benefits: BHC offers telehealth services to its patients in order to improve access to healthcare by enabling a patient to remain at home (or at a remote site) while receiving care.

Potential Risks: In the event of interruption with the audio/video connection, the continuity or completion of a particular telehealth visit will depend upon whether the information transmitted is sufficient for the patient's condition. If the audio/video connection is inadequate for that purpose or is disconnected, BHC may require an in-person visit. Your health information will be transmitted electronically by audio and video. In accordance with HIPAA regulations, BHC has implemented strict privacy and security precautions to protect its patients' health information; however, the security and confidentiality of information transmitted electronically may be compromised by the failure of these security safeguards or illegal or improper tampering. While BHC has taken reasonable and appropriate efforts to eliminate any confidentiality risks associated with your telehealth appointment, BHC cannot control or take responsibility for risks related to your environment or any company you may have with you during the telehealth appointment.

Medical Records: All existing State and Federal laws regarding the privacy and security of your medical records apply to this telehealth appointment, as detailed in the Notice of Privacy Practices. Your provider will document the medical information conveyed during the appointment into your medical record, the same procedure as if you had been seen in-person. You have the right to obtain copies of your medical records; any requests to inspect and obtain copies of medical records associated with telehealth will be made in accordance with BHC's standard policies and procedures.

Data and Devices: BHC does not warrant that its telehealth services will be compatible with any updates to, or prior versions of, your devices' operating systems. To the extent that your telehealth appointment requires the use of wireless, cellular data, or internet access, you are responsible for securing the necessary data access service. Your mobile phone provider may charge you data access fees in connection with your use of telehealth services. You are solely responsible for all such charges payable to third parties.

Regulatory Requirements: Due to state requirements, patients may only be seen when they are physically located in the state where the provider has an active medical license. Your provider may not be able to see you when you go on vacation or leave the state for other purposes. If you have medical needs outside of where you receive care with us, we recommend you receive healthcare where you are located. You can continue care with us when you return.

Patient Rights: You may withhold or withdraw your consent to telehealth at any time without affecting your right to future care or treatment. You may contact the practice for any questions you have related to telehealth services.

Acknowledgement: By signing below, you acknowledge that: 1) you have been advised of the potential risks, consequences, and benefits of telehealth; 2) you have had the opportunity to ask questions about the information presented in this form; and 3) you understand the information provided above.

Signature: _____

Date: _____

Email and Text Message Authorization

If you are interested in being contacted and communicating through email and/or text message, please read the below carefully. You may choose to not provide consent and this will not affect your treatment in any way.

I authorize Bloom Health Centers ("BHC") to communicate with me through electronic communications, including through email and/or text message. If I choose to communicate with BHC by these means, these communications may contain my personal and private medical information (including, but not limited to, my name, address, date of birth, types and dates of mental health care services received, medications, insurance coverage, and/or test results).

The following types of communications may be sent by email or text message:

- Appointment reminders
- Scheduling assistance
- Business updates
- New lines of treatment
- Wellness information

I may be charged through my phone carrier fees related to text messages with BHC. I assume all responsibility for these fees.

BHC will take reasonable measures to protect the privacy of my health information, however, there are inherent risks to communicating over the internet and through text message. By choosing to communicate with BHC via email and/or text, I assume this risk.

1. Email and text messaging is not appropriate for conveying information related to urgent or emergency medical matters. If I am experiencing an urgent or emergency situation, I understand that I should call the appropriate emergency services such as 911.
2. I should not use email or text communications for discussions of sensitive or highly confidential issues.
3. Certain other health care providers who are permitted access to my medical records (such as consulting providers) may have access to my email address, phone number and message contents.
4. I, and not BHC, am responsible for the security of emails sent from or stored on my computer, tablet, or phone.
5. My decision to allow BHC to communicate with me by email and/or text is voluntary, and treatment is not conditioned upon my election to do so.
6. I, or BHC, may stop email and/or text communications at any time for any reason.
7. I agree to notify BHC when my email address and/or my phone number changes.

8. I understand that all emails and text messages related to my care, received or generated by BHC, may be maintained in my medical record.

☐ I have read and understand the above

Please choose one option:
☐ I Agree to Email Communications
☐ I Do Not Agree to Email Communications

Please choose one option:
☐ I Agree to Text Communications
☐ I Do Not Agree to Text Communications

Signature: _____

Date: _____

Limits of Confidentiality

The confidentiality of your protected health information (PHI) is critical to us. PHI is information that is related to your health and can be used to identify you. Your PHI includes records that we create and obtain during your treatment, including records of your symptoms, examinations, test results, diagnoses, treatments, and referrals to other providers. It also includes bills, insurance claims, and additional payment information required for your care.
We take protecting your health information very seriously. However, in certain circumstances, we are required by State and Federal law to disclose patient information without consent in the following instances:

- Danger to Self: If a patient explicitly threatens to harm themselves, we are required to seek hospitalization or notify the patient's emergency contact.
- Danger to Others: If a patient presents a threat of serious bodily harm to another person, we are required to take protective actions, such as notifying the police or seeking hospitalization. If a patient discloses a plan to threaten or harm another person, and the provider is capable of contacting the person who may be in danger, the provider is required to warn them of the potential harm.
- Grave Disability: If a patient is unable to meet their basic needs due to mental illness, we are required to notify their emergency contact or a local agency that can assist.
- Suspicion of Child, Elder, or Dependent Abuse: Any indication of abuse (physical, sexual, emotional, neglect) to a child, an elderly person, or a disabled person ,even if the allegation is not about the patient, requires us to notify the local protective services agency.
- Judicial Proceedings: If a patient's mental health condition is directly related to legal proceedings, a judge may subpoena testimony from the provider.
- Minors/guardianship: Parents or legal guardians of non-emancipated minors have the right to access the minor's medical records unless there are legal reasons where the provider has discretion to disclose the minor's information. The provider may withhold the information for

certain minors if they believe the disclosure will harm the minor or deter them from seeking care.

☐ I have read and understand the above
Signature: _____

Date: _____

Termination of Treatment

You may stop or transfer treatment at any time. If you are considering ending treatment or transferring care, we encourage you to discuss your decision with your current provider in advance to ensure continuity of care.

Referrals: If your treatment needs to change, your clinician may recommend a treatment that he or she is not able to offer. Under these circumstances, your clinician may recommend transferring your care to a provider or practice more appropriate to your needs.

Termination: There are some instances where BHC will not continue to see a patient. The provider and/or the provider's staff may terminate this agreement for reasons including but not limited to:

1. The relationship between the provider and patient is no longer therapeutic.
2. I do not or will not follow the treatment plan.
3. I seek or obtain any controlled substance(s) from another source other than my BHC provider without receiving approval from my BHC provider prior to obtaining the substance.
4. I attempt to alter or forge a prescription.
5. I distribute my prescribed medications to another person.
6. My medical condition declines to a point at which, in the judgment of my provider, continued treatment at the current level presents danger to my wellbeing or safety.
7. I miss three appointments without prior notice ('no-shows').
8. I have not been paying my financial responsibility, including deductible, co-payment, coinsurance, or other fee.
9. I verbally or physically abuse or assault any BHC employees or volunteers.

If the decision is made to transfer or terminate treatment, your provider will provide short term treatment (30 days or less) while you transition to new providers. The time of coverage during transfer may be shorter if the recommendation is considered urgent. If there is a concern that your situation is unstable or unsafe, it may not be appropriate to continue the previously established treatment during the transition period. Patients will not be dismissed from the practice on the basis of any protected demographic or identity, including but not limited to limited English proficiency, sexual orientation, gender, etc.

☐ I have read and understand the above

Signature: _____

Date: _____

Standard Psychotherapy Treatment

Bloom Health Centers is dedicated to providing high-quality, whole-patient care. In order to ensure that your medication is the right fit for your lifestyle, our psychiatric care includes psychotherapy, an evidence-based approach to improve emotions and behaviors to positively affect the brain and body. Psychotherapy may include a variety of clinically tested approaches such as cognitive behavioral therapy, psychodynamic therapy, and supportive therapy. In your appointments this may look like an in-depth conversation about your mental health status, tips for coping with difficult life circumstances, building a treatment alliance, and more. Taking the time for this therapy will allow your provider to make a more informed decision when choosing a medication that may benefit you.

In order to provide this care, all of our medication management/follow up appointments are 30 minutes. There will therefore be two charges for medication management follow up appointments, one for the medication management activities and one for psychotherapy. Please contact us with any questions.

☐ I understand and acknowledge the above

Signature: _____

Date: _____

Consent to Treat

I have received the Bloom Health Center's patient information packet which includes information regarding patient rights, patient responsibilities, and privacy practices. I have been given the opportunity to review this information. I understand I may request a copy of any of this information if I wish to keep them for my personal reference.

I understand that behavioral health treatment offers no guarantees. My BHC healthcare providers will attempt to help me with the problems and concerns I bring to BHC, however, I recognize that even evidence-based interventions may be ineffective. I understand that there may be behavioral or emotional techniques or coping mechanisms that require practice outside of my appointments and that if I do not do these things, the effectiveness of my treatment may be limited.

I agree to adhere to treatment to the best of my ability. If I am unwilling or unable, I will discuss these reasons with my healthcare provider(s). I agree to ask any questions I have regarding therapeutic goals and how treatment is addressing them.

I understand that treatment will end once the problems and concerns I brought have been resolved. I also understand that I can terminate treatment at any time for any reason. I agree to notify my providers of my intent to end treatment and discuss the possible risks of premature termination of treatment.

I also understand that my healthcare provider may end my treatment if they identify that treatment is not benefitting me, or for other reasons based on their professional judgement. If treatment is to be terminated early for whatever reason, my healthcare provider may assist in finding another provider of my choice.

☐ I give permission for BHC and its employees or contractors to give me psychiatric mental health care including but not limited to medication management and psychotherapy.

☐ I understand that I am responsible for my entire fee. I authorize BHC to bill my insurance company and receive compensation for services rendered.

☐ Payment of deductibles/copay/coinsurance is expected at the time of service. In the event that my account becomes delinquent and is forwarded to an attorney for collection, I am responsible for the attorney fees and all court costs.

☐ I understand that behavioral health treatment offers no guarantees for improvement. I understand that my condition may worsen. I agree to make my best efforts to adhere to treatment or discuss reasons why I may not be able to. I agree to ask questions I have to clarify treatment goals and treatment plans.

☐ I acknowledge that I have been given copies of BHC’s Notice of Privacy Practices and my rights regarding HIPAA, the No Surprises Act, and Right to a Good Faith Estimate.

☐ I understand that I can revoke this consent at any time with written notice.

Patient Signature: _____

Patient Printed Name: _____

Signature of Guardian or
Legal Representative (if applicable): _____

Patient Date of Birth: _____ Date: _____