INFORMED CONSENT

This Informed Consent and Release of Liability is intended to provide you with important information regarding the practices, policies, and procedures; and to clarify the terms of the professional relationship. Any questions or concerns regarding the contents of this Agreement should be discussed prior to signing it.

Confidentiality

Of course, all of our work together – our conversations, your records, and any information that you give us – is protected by something called privilege. That means that the law protects you from having information about you given to anyone without your awareness and permission. Our office respects your privacy, and we intend to honor your privilege. However, there are limits to your privilege and legal exceptions that you should understand before we start.

If we believe there is a risk that you might harm yourself or someone else, we may be required to contact the authorities or the person to give them the opportunity to protect you or the other person. If we have cause to believe that you are abusing children or the elderly or disabled people, we are required by law to notify the authorities. Also, if you become involved in any lawsuit in which you claim mental health is an issue—for example, a child custody dispute or an injury lawsuit in which you claim compensation for emotional pain and suffering—then the court or the lawyers may insist upon, and may obtain your information from us.

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another third party payer, our office must share certain information with them, including (but not necessarily limited to) your diagnosis and the times of your visits. If there is a managed care company, they may require us to provide additional information, such as your symptoms and your progress. You should also understand that insurance & managed care information is often stored in national computer databases. If we find ourselves in a dispute with you over billing, our office may provide the collection company with information necessary to collect any outstanding balance.

# Our office policies and Fee & Payment Agreement

We schedule appointments and payment transactions at the beginning of the session; to avoid the interruption of thorough processes at the end of the session. Counseling sessions usually last 45-50 minutes, and we must end each session promptly.

* We can accept cash, checks, or credit cards for your payment.
* Our office has a No Cancellation Policy and charges the full session fee for missed/no-shows or if you are late, including missed rescheduled appointments.
* Scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours notice is required for re-scheduling or canceling an appointment. We will however offer a make-up session as a courtesy for paid missed sessions. It Does Not Replace already scheduled appointment.
* Our office charges a $35 fee for returned checks and a 3% fee on all credit card transactions.
* Our telephone is answered twenty-four hours a day by a digital answering system. Through the day, we check messages regularly, and whenever possible we try to return phone calls the same day. If we have not returned your call within twenty-four hours, please try again as your message may have been lost.
* If you have an emergency after 5:00 P.M. or on a weekend, call 911, or go to an emergency room.
* When we are out of the office for several days, the messages you leave may be answered by another counselor. We will probably not have discussed your case with that person, but he or she will make every effort to be helpful to you in our absence. If we have another professional taking calls while we are away, please find comfort that we have confidence that that professional is properly trained to be helpful to you. To the extent possible, we will keep you informed about when we are away from the office and when we will return.

Acknowledgement and Release of Liability

By signing below, you acknowledge that you have reviewed and fully understand the terms and conditions of this Agreement. You have discussed such terms and conditions and have had any questions with regard to its terms and conditions answered to your satisfaction. You agree to abide by the terms and conditions of this agreement and consent to participate in counseling and coaching.

Moreover, in consideration of the benefits to be derived from the counseling process, the receipt whereof is hereby acknowledged. You hereby indemnify and hold harmless, release, remise and forever discharge and covenant not to sue or hold legally liable; the owner of Thrive Wellness & Mediation, LLC, (Suyog Gandhi), Dr. Priyanka Upadhyaya, Psy.D, psychologist and the staff from any and all claims, demands, damages, actions, or causes of action whatsoever related to the counseling process.

I, (client’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read this Informed Consent and Release of Liability document. I understand it and agree to comply to the terms described.

|  |  |
| --- | --- |
| **Signature**. *Printed signature functions as agreement to terms & conditions.* | Date Signed |

Registration Form

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Client Name: | | Date of Birth: | | | | | Age: |
| Partner/ Spouses’ Name: | | Partner/ Spouses’ Date of Birth: | | | | | Age: |
| Client Address: | | | | City: | | | Zip: |
| Home Phone: | Cell Phone: | | | | Work phone: | | |
| Email Address: | | | | | | | |
| **Gender**: M F Trans\_\_\_\_\_\_\_\_\_  Other: | **Ethnicity**: **□**AA □White **□**Latino □Asian  **□**Others: | | | | | **Marital Status:**  S Domestic Partner M W D | |
| Social Security No.: | | | Place of Employment | | | | |
| Partner /Spouse Name: | | | Place of Employment | | | | |
| Psychiatrist Name & Tel Number: | | | Primary care physician Name & Tel Number: | | | | |
| Referred By: | | | May we thank this person for the referral?  Yes No | | | | |
| **Emergency Contact: [Name & Telephone no.]** | | | | | | | |

##### Release of Information & Assignment of Benefits

We are an out of network provider for insurance companies. Please make sure to verify your coverage prior to committing to services with Thrive Wellness & Mediation, LLC.

I understand that I am responsible for any charges or services not covered by my insurance company.

## NO Cancellation Payment Policy

Payment is kindly due at the time of service. Our office has a No Cancellation Policy and charges your full session fee for missed/no-shows or if you are late, including missed rescheduled appointments. Scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours notice is required for re-scheduling or canceling an appointment. We will however offer a make-up session as a courtesy for paid missed sessions. It Does Not Replace already scheduled appointment. Your insurance will not pay for missed sessions; these charges will be entirely your responsibility. Our office charges a $35 fee for returned checks and a 3% fee on all credit card transactions. Our collaboration is purposeful and significant. It gives you the tools and understanding necessary to have a thriving and fulfilled life. *It is the price whom one contributes towards one's evolving change….and we are both worth it.*

Please make all checks payable to Thrive Wellness & Mediation, LLC 1201 Maplecrest Dr. Edison, NJ 08820

|  |  |
| --- | --- |
| **Signature**: *Printed signature functions as agreement to terms & conditions.* | **Date:** |

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| **Payment Authorization Form** | Credit Card – ACH |

Thank you for choosing us as your partner in creating and living your best life! While your wellness is our priority, we still must charge for missed appointments. Please contact your insurance company with any questions you may have about

your coverage. The following questions may serve as a guide in helping you obtain pertinent information regarding eligibility and benefits.

|  |  |
| --- | --- |
| Kindly take time to read each statement and initial that you acknowledge and agree. Thank you. | Initial |
| At Thrive Wellness & Mediation, LLC we respectfully request for your credit card information to ‘hold’ your reserved appointment, similar to when reservation agents ask for a credit card to hold a hotel room or a table at a restaurant. This helps reduce no-shows, ensures the appointment is paid for cancellations & missed appointments |  |
| MISSED APPOINTMENTS. We understand that on rare occasions, true emergencies may arise. Our policy is to charge your full session fee for each missed/no-show therapy session including missed rescheduled appointments that are not rescheduled 48-hours in advance. Insurance health plans do not pay for missed appointments; these charges will be entirely your responsibility. |  |
| Patients have the option of providing a signed check, which we only deposit for no-shows. |  |
| Our office charges a $35 fee for any check returned for any reason and a 3% fee on all credit card transactions. Payments with a Flexible Spending Card is exempted from the 3% fee. |  |

Recurring Payments: How they work

You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an “ACH Debit.” You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (full name) authorize Thrive Wellness & Mediation, LLC to charge my credit card as payment indicated below for scheduled appointments for payment of my sessions/co-payment/co-insurance/deductible. These charges include full payments for missed appointment unless otherwise negotiated.

|  |
| --- |
| Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_  Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Credit Card**: Visa Master Amex Discover Other:  Cardholder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Exp. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV (AMEX 4 digit number front of card)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

SIGNATURE DATE

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Thrive Wellness & Mediation, LLC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Thrive Wellness & Mediation, LLC may at its discretion attempt to process the charge again within 30 days, and agree to an additional $30 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.  I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

CHECK THIS OUT AND LMK YOUR THOUGHTS.

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| --- | --- |
| **No Cancellation PAYMENT POLICY** | Insurance **о** Missed Appointment Fees |

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| --- | --- |
| Kindly take time to read each statement and initial that you acknowledge and agree. Thank you. | Initial |
| MISSED APPOINTMENTS. Rescheduling is preferred over cancellation. Weekly standing appointments are what we call “your time” meaning that we will honor “your time” in expectation of rendering you professional & courteous service for your scheduled appointment. Scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours notice is required for re-scheduling an appointment. If you miss or do not show up at “your time,” please be aware that you will be charged the full session feel for each missed/no-show therapy session including missed rescheduled appointments. Insurance health plans do not pay for missed appointments; these charges will be entirely your responsibility. We understand that on rare occasions, true emergencies may arise. We will do our absolute best to assist with rescheduling paid missed sessions due to true emergencies. Rescheduling appointments are highly dependent on availability that mutually converges for the client and counselor.  We will however offer only 2 make-up opportunities as a courtesy for paid missed sessions. Rescheduled sessions DO NOT replace already scheduled weekly appointments. |  |
| OUT OF NETWORK SERVICES: We are an out of network provider and do not take health insurance. We would be glad to provide a super bill to submit to your insurance company or your third party flexible spending account payor. Hence you will be responsible to pay for services in full at the time of visit.  In addition to your weekly appointments, please note that we charge an hourly rate for other professional/legal services you may need such as report writing, mental health assessments, telephone conversations longer than 15 minutes, teleconferences with other professionals you have authorized, preparation of records and/or treatment summaries, etc. |  |
| NONPAYMENT. Please bear in mind that should your account remain unpaid in 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information released regarding a patient’s treatment is his/her name, the nature of services provided, and the amount due. |  |
| CLAIMS SUBMISSION. We will provide you with a super bill & assist to help get your claims paid. |  |
| SELF-PAYMENT Periodically, fees will be increased; no more than once per year with the courtesy of advanced notice where you are encouraged to express any financial concerns with your therapist. |  |
| RETURNED CHECK FEE. Our office charges a $30 fee for any check returned for any reason. |  |
| CREDIT CARD FEE Our office charges a 3% fee on all credit card transactions. Payments with a Flexible Spending Card is exempted from the 3% fee. |  |

Our practice is committed to providing you with the best treatment. Our fees are representative of the usual & customary charges for our area. Thank you for understanding our payment policy. Let us know if you have questions or concerns.

* *I have read, understand, and agree to the above Payment Policy.*
* *I authorize Thrive Wellness & Mediation, LLC to release pertinent medical information to either my medical provider, insurance company or this party benefits management company as deemed appropriate, when requested, or to facilitate payment of a claim.*

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| --- | --- | --- |
| Signature of patient or responsible party | Printed Name | Date |
|  |  |  |

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc.

Include prescription, over-the-counter, herbal, vitamin, and diet supplement products.

Also list any medicine you take only on occasion

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| --- | --- |
| **Patient** **Name:** | **DOB:** |

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| --- | --- | --- | --- | --- | --- | --- |
| Medication Name | Dose | How do you take it? | How **often** do you  take it? | Reason for taking | Date  Started/ Changed | Healthcare  Provider |
|  |  | □Mouth □Inject |  |  |  |  |
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| Allergies (please describe reaction) | | |
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| --- | --- | --- |
| Doctor’s Name | Phone Number | Type of Practitioner / Reason for Seeing |
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## Health Insurance Portability Accountability Act (HIPAA)

##### Client Rights & Therapist Duties

##### This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

##### HIPAA requires that we at Thrive Wellness & Mediation LLC provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail.

##### The law requires that we obtain your signature acknowledging that we have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it.

##### LIMITS ON CONFIDENTIALITY

##### The law protects the privacy of all communication between a patient and a therapist. In most situations, Dr. Priyanka Upadhyaya can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where Dr. Priyanka Upadhyaya, Psy.D permitted or required to disclose information without either your consent or authorization. If such a situation arises, we will limit disclosure to what is necessary. Reasons we may have to release your information without authorization:

##### If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. Dr. Priyanka Upadhyaya, Psy.D cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if we receive a subpoena of which you have been properly notified and you have failed to inform us that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order Dr. Priyanka Upadhyaya, Psy.D to disclose information.

##### If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, we may be required to provide it for them.

##### If a patient files a complaint or lawsuit against Thrive Wellness & Mediation LLC or Dr. Priyanka Upadhyaya, Psy.D, we may disclose relevant information regarding that patient in order to defend myself.

##### If a patient files a worker's compensation claim, and Dr. Priyanka Upadhyaya, Psy.D is providing necessary treatment related to that claim, we must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier ( if applicable) or an authorized qualified rehabilitation provider.

##### Dr. Priyanka Upadhyaya, Psy.D may disclose the minimum necessary health information to her business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

##### There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a patient's treatment:

##### If we know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that Dr. Priyanka Upadhyaya, Psy.D file a report with the NJ, NYS Abuse Hotline and provide the necessary information.

##### If we know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that Dr. Priyanka Upadhyaya, Psy.D file a report with the NJ, NYS Abuse Hotline and provide the necessary information.

##### If we believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, Dr. Priyanka Upadhyaya, Psy.D may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

##### CLIENT RIGHTS AND THERAPIST DUTIES

##### Use and Disclosure of Protected Health Information:

##### ***For Treatment*** – Information may be shared with other providers outside this office if they are involved in your treatment for the purpose of providing medical treatment and psychotherapy. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.

##### ***For Payment*** – We may use and disclose your health information to obtain payment for services provided to you.

##### ***For Operations*** – We may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

##### We may call you, text you, speak to you or leave a message with someone or an answering machine regarding your upcoming appointment.

##### Patient's Rights:

##### ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.

##### ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.

##### ***Right to Request Restrictions*** *–* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

##### ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** *–* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.

##### ***Right to Inspect and Copy*** *–* You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

##### ***Right to Amend*** *–* If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.

##### ***Right to a Copy of This Notice*** *–* If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.

##### ***Right to an Accounting*** *–* You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, we will discuss with you the details of the accounting process.

##### ***Right to Choose Someone to Act for You*** *–* If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.

##### ***Right to Choose*** *–* You have the right to decide not to receive services with Dr. Priyanka Upadhyaya, Psy.D. If you wish, we will provide you with names of other qualified professionals.

##### ***Right to Terminate*** *–* You have the right to terminate therapeutic services with us at any time without any legal or financial obligations other than those already accrued. We ask that you discuss your decision in session before terminating or at least contact us by phone letting me know you are terminating services.

##### ***Right to Release Information with Written Consent*** *–* With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not releasing the information in question to that person or agency might be harmful to you.

##### Therapist’s Duties:

##### Dr. Priyanka Upadhyaya, Psy.D is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, Dr. Priyanka Upadhyaya, Psy.D is required to abide by the terms currently in effect. If we revise my policies and procedures, we will provide you with a revised notice in office during our session.

##### COMPLAINTS

##### If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may contact us, the State of NJ or NY, Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

##### YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

##### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Client/Legal Guardian Signature Date

##### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Printed Name

##### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Client/Legal Guardian Signature Date

##### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Printed Name

##### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Dr. Priyanka Upadhyaya, Psy.D Date