HEALTHY MINDS FOR HEALTHY LIVES

Merrill Wood DNP, APRN, CPNP-PC, PMHS, BICBT-CC
www.healthymindsforhealthylives.com
admin@healthymindsforhealthylives.com
940-757-1943

WELCOME

Welcome to Healthy Minds for Healthy Live-Pediatric Mental Health and Wellness, PLLC.

I appreciate you taking a moment out to read this. I want to thank you for choosing us to provide for you/your child's mental health care needs and goals. I appreciate and acknowledge the courage it takes to want to make a change, and I am delighted, honored and privileged to be working with you through this journey.

I see my patients as individuals who each have specific and personal mental health care needs and goals for treatment. I truly care for all patients and work diligently to help provide the help they need. I we strive to provide the best primary pediatric mental health care for children, adolescents, and young adults.

You/your child will have the most success by completing the goals you/your child came to achieve. Please know that should you choose to refer a potential patient to work with me that both of your information is confidential and protected under HIPAA guidelines. Healthy Minds for Healthy Live-Pediatric Mental Health and Wellness, PLLC does not share information with others without your consent.

I look forward to getting started with you at your first appointment. Should you have any questions prior to our appointment please feel free to give me a call/text at 940-757-1943 or email at admin@healthymindsforhealthylives.com

Under HIPAA law, HIPAA does not prohibit the electronic transmission of PHI. Electronic communications, including email, are permitted, although HIPAA-covered entities must apply reasonable safeguards.

Kindly,

Merrill Wood DNP, APRN, CPNP-PC, PMHS, BICBT-CC

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DISCLOSURE STATEMENT

Pediatric Mental Health Specialist Training, Orientation, General Information, and Counseling Fees, Confidentiality, Consent

Training and Degrees: I am a Doctor of Nursing Practice and obtained this degree through The Ohio State University. I have a Master's of Science in Nursing from Texas Tech Health Science Center. I hold a professional certification as a pediatric nurse practitioner and a pediatric mental health specialist from the Pediatric Nursing Certification Board. I have been working in pediatric nursing for the last 16 years. I worked in a private practice setting as well as a federally qualified community health care center where I saw children from across a large age range, socioeconomic levels, education levels, and ethnicities. I am credentialed in Texas an advanced practice nurse and registered nurse. Additionally, I am a Beck's Institute Cognitive Behavioral Therapy (CBT) Certified Clinician. I am certified to deliver cognitive behavioral therapy to children, adolescents, and young adults.

Mental Health Services Orientation: I have an eclectic approach to helping children with mental health needs. I am rooted in evidence-based practice and see great benefit in using patient-centered care. I provide CBT and I am able to prescribe medication if needed to help with mental health needs but will not prescribe any controlled substances.

Fees: The self-pay fee for our service is **$130** for an initial consultation and then **$110** per 55-minute appointments, and **$60** per 30- minute appointments. Medication Management Only **$55.00** per 20 minutes, no counseling services except medication management will be given. Fees are adjusted annually on January 1 and will not increase more than 10% per year. **Payments (cash, check, or credit) are to be made at the beginning of each appointment. All sales are final for services**. A **$30** fee will be charged for returned checks. Unpaid balances incur the maximum finance charge allowed by law after 30 days. Outstanding balances may be sent to a collection agency.

Medication: If you/your child is given a prescription for medication under the care of Healthy Minds for Healthy Lives, I require you/your child(ren) to keep appointments, and you must agree for you/your child(ren) to take medications as prescribed. I also require that patients who are on medication have regular appointments for medication management and are seen at least monthly for 3 months and then at least every 3 months once you/your child is on a dose determined to be effective by Merrill Wood with Healthy Minds for Healthy Lives.

Missed Appointments: In the event that you are unable to keep an appointment, please notify me via phone or text a minimum of two days (48-hours) in advance. E-mail is not adequate notice. **If you miss your appointment for whatever reason and fail to give me adequate notice, you will be responsible for the full fee for the session.** If you are late, I will still stop at our regular ending time in order to keep my schedule, and you will still be required to pay for the entire appointment. In the event of a missed appointment, the bill will reflect a late cancellation instead of a clinical session. Most insurance companies will not reimburse for missed appointments. If I have an emergency, I will notify you as soon as possible of my need to reschedule our appointment. ***If you cancel or reschedule more than twice, we may re-evaluate your needs, desires, and motivations***

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for treatment at this time. You risk your child being dismissed from our practice. The clinician reserves the right to terminate the counseling relationship if more than 3 sessions are missed without proper notification.

Phone Calls: I charge hourly rate in quarter hours for phone calls over 10 minutes in length for continuity of care. All costs for services outside of session will be billed. Your account will be charged for phone calls in excess for phone calls over 10 minutes in length. The cost is as follows: 11-20 minutes $30.00, 21-30 minutes $40.00, and over 30 minutes $50.00.

Copies of Medical Records: Should you request a copy of your medical records, the cost is $1.00 per page. Payment for your medical records will be due prior or upon receipt and can be mailed. Please allow at least 2 weeks to prepare medical records.

Social Media and Telecommunication: Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former patients on any social networking site (Facebook, LinkedIn, etc). I believe that adding patients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Termination of Treatment: When you wish to terminate treatment, please give a minimum of one week's notice. You may terminate treatment at any time without moral, legal, or financial obligation beyond payment of services already rendered. It is expected that we will discuss the prospect of termination so that both parties will be clear about any details that need attention as part of the termination process. If you fail to schedule a future appointment, cancel a scheduled appointment, or fail to keep a scheduled appointment and do not contact me within 30 days of the date of last recorded contact, it will be understood that you have terminated treatment. I shall have no further obligation to you once treatment has been terminated. The clinician reserves the right to terminate the counseling relationship if more than 2 sessions are missed without proper notification.

Testifying in Court: Healthy Minds for Healthy Lives-Pediatric Mental Health and Wellness, PLLC providers are dedicated to our patients and providing high quality mental health care for your child(ren). Our focus is on your child's mental health. We are not party to nor are we involved in any legal issues involving divorce, separation, or custody agreements.

If you become involved in any legal proceedings that require my participation, you will be expected to pay for all of my professional time. This includes any preparation and transportation time, even if I am called to testify by another party. Because of the difficulty of legal involvement, **I charge $400 per hou**r for preparation and travel, for attendance (waiting and participation) at any legal proceeding. Having said this, I am not a certified child custody evaluator and will be unable to help you legally if this is your purpose in pursuing treatment with me.

Insurance Claims: Healthy Minds for Healthy Lives-Pediatric Mental Health and Wellness, PLLC providers are dedicated to our patients and providing high quality mental health care for you/your child(ren). Our focus is on your child's mental health. We are not party to nor are we involved in

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any legal issues involving insurance claims, work man's compensation, disability applications or any other short or long term disability forms.

Choosing a Mental Health Provider: You have the right to choose a mental health provider who best suits your needs and purposes. You may seek a second opinion from other mental health providers or may terminate therapy at any time.

State Mandated Disclosure: I have broad discretion to release any information that I deem relevant in situations where I believe my patient or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect.

Consultations: I regularly consult with the medical director, Dr. Jennifer Cabler, regarding patients with whom I am working. This allows me to gain other perspectives and ideas about how to better help you reach your goals. These consultations are conducted in such a way that confidentiality is maintained. This is required by the Texas Board of Nursing and the Texas Medical Board.

Unprofessional Conduct: If you suspect that my conduct has been unprofessional in any way, please contact the Texas Board of Nursing.

Contacting Me by Phone: If you need to contact me between sessions (940) 757-1943, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours unless it is a Saturday or Sunday and your call will be addressed the next regular business day. In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255. If either you or someone else is in danger of being harmed, text/call 988 or go to your nearest emergency room.

Emergencies: If you are in an emergency situation and cannot reach me, please call one of the following numbers for help: **General Emergencies: 988, Crisis Hotline: 1-800-273- TALK (8255)**

Informed Consent for Mental Health Services

General Information: The patient provider relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Treatment Process: You have taken a very positive step by deciding to seek mental health services and treatment for you/your child. The outcome of your treatment depends largely on you/your child's willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and

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do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for you/your child. If at any point I feel you/your child requires a higher level of care, I will refer you to a psychiatrist or psychiatric mental health nurse practitioner.

Confidentiality: The appointment content and all relevant materials to the patient's treatment will be held confidential unless the patient or parent requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a patient threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a patient threatens grave bodily harm or death to another person.
3. If the nurse practitioner has a reasonable suspicion that a patient or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years. Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena. If a patient is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
7. Fee Disputes: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the "Therapy Consent & Agreement" that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
8. Law Enforcement and Public Health: A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.
9. Victim of a Crime: Limited information, in response to a law enforcement official's request for information about you if you are suspected to be a victim of a crime; however,

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except in limited circumstances, we will attempt to get your permission to release information first.

10. Court Ordered Treatment: If therapy/treatment is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
11. Written Request: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "mental health/progress notes", except if the third party is part of the medical team. If therapy/treatment sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
12. Parental/Guardian Conflict & "No Secret" Policy: When working with parents/guardians, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to the child's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your child's goals then become counter-productive. However, if one party requests a copy of your child's or family therapy records in which they participated, an authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.
13. Dual Relationships & Public: Our relationship is strictly professional. In order to preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (i.e.: social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
14. Social Media: No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical record.
15. Electronic Communication: If you need to contact me outside of our sessions, please do so via phone.
    1. Clients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges into the therapist–client relationship**.** Texting is not a substitute for sessions. Phones can be lost or stolen. DO NOT communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of the client's phone.
    2. Do not use email for emergencies. In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment.
    3. E-mail is not confidential**.** Do not communicate sensitive medical or mental health information via email if you do not feel comfortable. HIPAA does not prohibit the electronic transmission of PHI. **Electronic communications, including email, are permitted**, although HIPAA-covered entities must apply reasonable safeguards

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when transmitting ePHI to ensure the confidentiality and integrity of data. If the use of unencrypted e-mail is unacceptable to a patient who requests confidential communications, other means of communicating with the patient, such as by more secure electronic methods, or by mail or telephone, is be offered and will be accommodated.

4. Furthermore, if you send email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.

16. Sessions Outside the Office: From time to time, clients like to meet in an alternate location (i.e. their home, in public, or somewhere more conducive for them). We may be able to accommodate this request, however, this can put your confidentiality at risk.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

REASONS I DO NOT ACCEPT ALL INSURANCE TYPES AT THIS TIME

Reduced Ability to Choose: Most health care plans today (insurance, PPO, HMO, etc.) offer little coverage and/or reimbursement for mental health services. Most HMOs and PPOs require "preauthorization" before you can receive services. This means you must call the company and justify why you are seeking therapeutic services in order for you to receive reimbursement. The insurance representative, who may or may not be a mental health professional, will decide whether services will be allowed. If authorization is given, you are often restricted to seeing the providers on the insurance company's list. Reimbursement is reduced if you choose someone who is not on the contracted list; consequently, your choice of providers is often significantly restricted.

Pre-Authorization and Reduced Confidentiality: Insurance typically authorizes several therapy/treatment sessions at a time. When these sessions are finished, your mental health provider must justify the need for continued services. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not completely met. Your insurance company may require additional clinical information that is confidential in order to approve or justify a continuation of services. Confidentiality cannot be assured or guaranteed when an insurance company requires information to approve continued services. Even if the mental health provider justifies the need for ongoing services, your insurance company may decline services. Your insurance company dictates if treatment will or will not be covered. Note: Personal information might be added to national medical information data banks regarding treatment.

Negative Impacts of a Psychiatric Diagnosis: Insurance companies require clinicians to give a mental health diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") for reimbursement. Psychiatric diagnoses may negatively impact you in the following ways:

1. Company (mis)control of information when claims are processed;
2. Loss of confidentiality due to the increased number of persons handling claims;

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3. A psychiatric diagnosis can be brought into a court case (ie: divorce court, family law, criminal, etc.).

It is also important to note that some psychiatric diagnoses are not eligible for reimbursement.

Blue Cross Blue Shield: I am credentialed with some BCBS policies. **However, I cannot guarantee all mental health services will be covered by BCBS or that your specific plan is accepted. To ensure your plan is accepted, please contact BCBS of Texas to ensure coverage. If you choose to file with BCBS and they do not cover all of the services provided then you will be responsible for any outstanding charges not covered by insurance. It is your responsibility to determine if I am within your network.**

If I am not covered by your BCBS policy or if you choose to file with another different insurance company, you can submit your proof of payment for reimbursement but this is not guaranteed. If you would like a mental health provider who does take your insurance, I will attempt to provide you with a list of therapists on your insurance provider list, I will do my best to recommend a therapist/provider for you.

EMERGENCY CONTACT:

It is necessary that **Merrill L Wood** of **Healthy Minds for Healthy Live-Pediatric Mental Health and Wellness, PLLC** has someone to contact on your behalf. In case of an emergency who should we contact?

Full Name: _____ Relationship: _____

Phone Number(s): _____

Please check here that you agree and sign below.

☐ I agree to allow **Healthy Minds for Healthy Live-Pediatric Mental Health and Wellness, PLLC** to contact my emergency contact on my behalf in the case of emergency.

Patient Name: _____ Date: _____

Guardian Signature: _____ Date: _____

Signatures

I have read and understand the information present in this form

Patient Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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HIPAA COMPLIANCE NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you/your child may be used and disclosed, and how you can get access to this information. This information will include Protected Health Information (PHI), as that term is defined in privacy regulations issued by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, as applicable, RCW Chapter 70.02 entitled "Medical Records - Health Care Access and Disclosure." Please review it carefully.

We respect your privacy. We understand that your/your child's personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Protected Health Information:

Protected health information means individually identifiable health information:

- Transmitted by electronic media.
- Maintained in any medium described in the definition of electronic media; or
- Transmitted or maintained in any other form or medium. **Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations For treatment:**
- Information obtained by a nurse, physician, clinical psychologist, MSW, therapist, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- In Texas, written patient permission is required to use or disclose PHI for payment purposes, including to your health insurance plan. We will have you sign another form Assignment of Benefits or similar form for this purpose. Health plans need information from us about your medical care. Information provided to health plans may include your diagnosis, procedures performed, or recommended care.

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For health care operations:

- We use your medical records to assess quality and improve services.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including medical quality review by your health plan, accounting, legal, risk management, and insurance services, audit functions, including fraud and abuse detection and compliance programs.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we create, and store are the property of health care provider. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in12months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose were to obtain insurance.

For help with these rights during normal business hours, please contact our Privacy Officer:
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Tel: (940) 757-1943

Email: admin@healthymindsforhealthylives.com

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OUR RESPONSIBILITIES

We are required to:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice.

OUR RESPONSIBILITIES

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by requesting our office or medical records department to email a copy.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact our Privacy Officer at the above address. If you believe your privacy rights have been violated, you may discuss your concerns with the Privacy Officer. You may send a written complaint to the Texas State Department of Health. You may also file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

We may use and disclose your protected health information without your authorization as follows:

- **With Medical Researchers**—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
    - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
    - to public health or legal authorities
    - to protect public health and safety
    - to prevent or control disease, injury, or disability
    - to report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.

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- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities**. For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes**. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health**. For example, an employer may ask us to assess health risks on a jobsite.
- **To the Military Authorities of U.S. and Foreign Military Personnel**. For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions**. For example, we may share information for national security purposes.
- **To Coroners, Medical Examiners, Funeral Directors**. We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death. In addition, we may disclose PHI to funeral directors, as authorized by law, so that they may carry out their jobs.
- **Organ and Tissue Donations**. If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate, and transplant organs in order to facilitate an organ, eye or tissue donation and transplantation.
- **Incidental Disclosures**. We may use or disclose PHI incident to a use or disclosure permitted by the HIPAA Privacy Rule so long as we have reasonably safeguarded against such incidental uses and disclosures and have limited them to the minimum necessary information.
- **Limited Data Set Disclosures**. We may use or disclose a limited data set (PHI that has certain identifying information removed) for purposes of research, public health, or health care operations. This information may only be disclosed for research, public health, and health care operations purposes. The person receiving the information must sign an agreement to protect the information.

SPECIAL AUTHORIZATION

Certain federal and state laws that provide special protections for certain kinds of personal health information call for specific authorizations from you to use or disclose information. When your personal health information falls under these special protections, we will contact you to secure the required authorizations to comply with federal and state laws such as:

- Uniform Health Care Information Act (RCW 70.02)
- Sexually Transmitted Diseases (RCW 70.24.105)
- Drug and Alcohol Abuse Treatment Records (RCW 70.96A.150)
- Mental Health Services for Minors (RCW 71.05.390-690)
- Communicable and Certain Other Diseases Confidentiality (WAC246-100-016)
- Confidentiality of Alcohol and Drug Abuse Patients (42 CFR Part2)

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If we need your health information for any other reason that has not been described in this notice, we will ask for your written authorization before using or disclosing any identifiable health information about you. Most important, if you choose to sign an authorization to disclose information, you can revoke that authorization at a later time to stop any future use and disclosure.

Other Uses and Disclosures of Protected Health Information

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Effective Date: 01/01/2022

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND FINANCIAL AGREEMENT

(Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and RCW 70.02.120)

Merrill Wood keeps a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer. Written requests should be made to the Privacy Officer at the following address:

Merrill Wood

1106 Travis Street #120

Wichita Falls, Texas 76301

Tel: (940) 757-1943 Email: admin@healthymindsforhealthylives.com

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

HEALTHY MINDS FOR HEALTHY LIVES

Merrill Wood DNP, APRN, CPNP-PC, PMHS, BICBT-CC
www.healthymindsforhealthylives.com
admin@healthymindsforhealthylives.com
940-757-1943

PATIENT ACKNOWLEDGMENT
BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

VERIFICATION OF MEDICAL CONSENT: I, the undersigned, hereby agree and consent to the plan of care proposed to me by the Covered Entity. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse medical care. I will ask for any information I want to have about my medical care and will make my wishes known to the Covered Entity and/or its staff. The Covered Entity shall not be liable for the acts or omissions of others. I have discussed any questions that I have regarding this information with **Merrill L Wood**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling/mental health services for my child and agree to abide by the agreement and policies listed in this consent. I authorize **Merrill L Wood** to provide counseling and mental health services that are considered necessary and advisable.

AUTHORIZATION TO RELEASE INFORMATION – IF APPLICABLE: I, the undersigned, hereby authorize the Covered Entity and/or its staff, to the extent required to assure payment, to disclose any diagnosis and pertinent medical information to a designated person, corporation, governmental agency or third party payer which is liable to the Covered Entity for the Covered Entity's charges or who may be responsible for determining the necessity, appropriateness, or amount related to the Covered Entity's treatment or charges, including medical service companies, insurance companies, workmen's compensation carriers, Social Security Administration, intermediaries, and the State Department of Health and Human Services when the patient is a Medicaid or Medicare recipient. I authorize the **release of treatment and diagnosis information** necessary to process bills for services **to my insurance company**, and request payment of benefits to **Merrill L Wood,** of **Healthy Minds for Healthy Live-Pediatric Mental Health and Wellness, PLLC**. This consent shall expire upon final payment relative to my care.

FINANCIAL AGREEMENT:
PRIVATE PAY: I, the undersigned, hereby agree, whether signing as agent or as a patient/guardian, to be financially responsible to the Covered Entity for all charges not paid by insurance. I understand this amount is due at the beginning of the session. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, **Merrill L Wood,** of **Healthy Minds for Healthy Live-Pediatric Mental Health and Wellness, PLLC** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

CONSENT TO TREATMENT OF MINOR CHILDREN: I hereby certify that I have the legal right to seek counseling/mental health treatment for minor(s) in my custody and give permission to Merrill L Wood to provide treatment to my minor child(ren). If I have unilateral decision-making capacity to obtain counseling/mental health services for my minor, I will provide the appropriate court documentation to **Merrill L Wood** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Your signature signifies that you have received a copy of the "Therapy Agreement, Policies and Consent" *for your records.*

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INSURANCE COVERAGE – IF APPLICABLE: I certify that the information given to me in applying for payment under government or private insurance is correct. I hereby assign payment directly to the Covered Entity for benefits otherwise payable to me. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable within thirty (30) days of invoice. **I understand the Covered Entity will verify my insurance coverage but that this does not guarantee payment by the insurance company, and I will be responsible for all non-covered charges. I understand that it is my responsibility to determine the coverage limits of my insurance**.

I have read and understand the information present in this form.

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Date: _____

Relationship to the Patient: _____

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PATIENT ACKNOWLEDGMENT *(CLIENT COPY TO KEEP)*
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I understand a minimum monthly fee of 1% (annual rate of 12%) may be charged for late payment on all balances not covered by insurance. This is in addition to a charge for reasonable attorney fees, court costs, and collection agency expenses incurred to collect the amount due.

I have read and understand the information present in this form.

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Date: _____

Relationship to the Patient: _____

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By signing this form, I certify:

That I have read or had this form read and/or had this form explained to me. That I fully understand its contents including the risks and benefits of the mental health treatment.. That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction I have read and understand the information provided above.

Patient Name:_____

Parent/Guardian Signature:_____

Date: _____

(parent, legal guardian, personal representative)