BOSC
Mental Health

INFORMED CONSENT TO TREAT WITH MEDICATION

I, _____, do hereby authorize my prescribing working for BOSC Mental Health to prescribe the following medication(s):

_____

_____

I understand that the reason this/these medication(s) are being prescribed is to treat my illness. Furthermore, by signing this **Consent Form** I am confirming that my provider has informed me of the nature of the treatment, the type of medication that I am taking and any subsequent risks or side effects associated with this/these medication(s). I also confirm that I understand the risks and side effects associated with this/these medication(s).

Please check and initial one choice below:

☐ I am allergic to: _____ _____
Initials

☐ I have no known Allergies _____
Initials

Female Patients:

☐ **Yes, I am pregnant.** My provider informed me of potential risks to me and my developing, new-born, or breastfed baby that may occur due to taking this/these medication(s) while pregnant/breastfeeding. My provider explained that I will be referred to my Gynecologist at this time for continued psychiatric care alongside my maternity care. Once I deliver my baby, I will return to BOSC Mental health for continued psychiatric care. _____
Initials

☐ **No, I am not pregnant.** I understand that taking this medication(s) may carry Risk of harm to a developing, new-born, or breastfed baby. I agree to discuss any plans for Pregnancy with my provider as soon as possible, if applicable. _____
Initials

I understand that I many not be compelled to take this/these medication(s) and that I may discontinue this/these medication(s) at any time. However, I further understand that if I stop taking this/these medication(s) I may experience serious side effects, and therefore, I should not discontinue taking the medication without the awareness and active participation of my prescribing provider.

OFF LABEL MEDICATION: Off-Label medication is defined as: The use of a drug to treat a condition or target symptom(s), even though the drug is not specifically approved to do so by the US Food and Drug Administration (FDA).

BLACK BOX WARNING: Black Box Warnings are defined as: The strictest warning put in the labelling of prescription drugs or drug products by the US Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug.

My signature below indicates that:

1. I understand the contents of this release as well as my rights with respect to agreeing to or refusing any medication suggested to treat my illness.
2. This consent form was discussed with me in detail and that all my questions were answered to my satisfaction.
3. The nature and rationale of treatment with this/these medication(s), explanation of possible side effects (including black box warnings) and whether this/these medication(s) is/are being prescribed for "OFF LABEL" use was also discussed and I have no further questions. Signing indicates that I believe the benefits of treatment outweigh the risks.

Patient Signature: _____ Date: _____
Typing Your Name Here Constitutes Legal Signature

Parent/Guardian Signature: _____ Date: _____
Typing Your Name here Constitutes Legal Signature

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Contract for the Prescription of Controlled Substances

1) I agree to only take my medication(s) as prescribed. This includes how often I take the medication(s) and dose. My provider discussed what I should do if I have questions about the medication or side effects after starting to take it (including conditions where I should stop the medication until I can discuss how to proceed directly with my provider).

2) I have disclosed all of my medications, supplements & vitamins to my provider. I am responsible for updating my provider with any changes to this list.

3) I understand that the medication(s) that I am being prescribed has abuse potential – and that being prescribed this medication puts me at risk for developing a substance problem. I also understand that this medication may cause physiological dependence, tolerance and withdrawal. These side effects and risks have been described to me in detail and I understand the above terms and risks.

4) I understand that my practitioner may require drug testing while under his/her care. Results that are inconsistent with my medical history, medications prescribed or results suggesting that I may have a substance problem (for example testing positive for illegal drugs or medications that I am not prescribed), may be grounds for termination of care at my provider's discretion.

5) I understand that I always have the right to refuse or stop taking my medication(s), but that doing so may result in withdrawal symptoms (with potentially severe medical consequences). If I decide to stop a medication or decrease my dose without direct supervision from my provider, he/she is not responsible for any serious adverse reactions or consequences (including seizure and/or death).

6) If there is concern for medication abuse, diversion (giving or selling the medication to others) or "doctor shopping" (obtaining similar medications from multiple prescribers), my care will be terminated at my provider's discretion. My provider has the right to contact proper authorities (such as the police, DEA etc.) if there is concern that this is occurring. Signing this form gives my provider permission to share my medical record (including drug screens) with any law enforcement agency, medical provider and pharmacy if my provider has a concern. BOSC Mental Health or any of its providers are not responsible for any legal repercussions that I incur, should this occur.

7) My practitioner may contact all of my current and previous providers and pharmacies at their discretion. Reasons include (but are not limited to) notifying them of this contract.

8) <u>If I am not adherent to this contract, honest about my medications and/or doses, do not take medications as prescribed, am not honest with my provider about a history of substance abuse or dependence or do not notify my prescriber should I have concern that I am developing a substance problem, I am solely responsible for any adverse outcomes.</u>

Signing this form indicates that I fully understand all of the above, all of my questions have been answered and I agree to my prescriber's terms for being a patient.

_____ _____

Patient Signature - Typing Your Name Here Constitutes Legal Signature Date

_____ _____

Witness Signature - Typing Your Name Here Constitutes Legal Signature Date

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Patient Date of Birth: _____

I authorize my provider(s) and staff at BOSC Mental Health to release and/or receive information (medical, mental health, and addiction-related information) to/from:

Name: _____ Phone: _____

Address: _____ Fax: _____

Information to be released (check one or more):

___ Any/all treatment-related records or information (history, evaluations, all notes, studies, lab work, diagnosis, formulations, treatments, payment information, email correspondence and others [my entire medical record]).
___ A summary of relevant parts of my care (relevance determined by my provider)
___ Other: _____

Purpose of disclosure (check one or more):

___ To coordinate/plan care with other providers (for example with my therapist, specialist, or primary care provider)
___ To secure medical leave or disability (such as FMLA or medical leave from school)
___ Transition of care to a new provider
___ Other (i.e. legal, school/workplace accommodations): _____

I understand that the parties above may participate in periodic exchanges of information (written or verbal) for the purposes described above.

I understand that I have a right to meet with my clinician to inspect my medical, mental health and addiction treatment record.

I understand that BOSC Mental Health providers/staff cannot be held responsible for negative consequences, including legal liability, that may arise as a result of their compliance with this request.

I understand that this consent may be revoked at any time, but any action that has been taken in reliance thereon cannot be changed.

By signing below, I attest that I have read this form, understand its content, and request that the above information be released/exchanged as specified.

Signature: _____ Date: _____
Typing Your Name Here Constitutes Legal Signature

Witness: _____ Date: _____
Typing Your Name Here Constitutes Legal Signature

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TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, email, patient portals and remote patient monitoring are all considered telehealth services.

Patient Name: _____ Date of Birth: _____

1. I understand that telehealth involves the communication of my medical and mental health information in an electronic or technology assisted format (phone, videoconferencing and others).
2. I understand that I may opt out of telehealth visits at any time. This will not change my ability to receive future care at BOSC Mental health, but may affect my ability to see my current provider.
3. I understand that telehealth services can only be provided to patients, including myself, who are physically located in the state of **FLORIDA**, at the time of their visits. If my provider is also licensed in any other state, then I may also have telehealth visits when I am physically located in that state as well (it is my responsibility to discuss with BOSC Mental Health staff where my provider is licensed, and it is my responsibility to notify them should I no longer be able to have appointments from a state where my provider is licensed).
4. I understand that telehealth billing information is collected in the same manner as regular office visits, and visit fees are the same for face-to-face visits and telehealth visits at BOSC Mental Health.
    a. I understand that if technology fails for a videoconferencing session, the visit will be moved to a phone appointment, and there will be no change in visit fees (I will still be responsible for the full visit fee).
5. If I have out-of-network health insurance benefits for mental health services, it is my responsibility to discuss with my insurance company, whether they reimburse for telehealth appointments. Our fees do not change whether a patient's insurance company accepts telehealth as a reimbursable expense, and it is my responsibility to research before making appointments with this office.
6. I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include, but are not limited to:
    a. It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
    b. Electronic systems that are accessed by employers, friends or others are not secure and should be avoided. It is important for me to use a secure network.

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c. Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.
d. Telehealth visits could be "hacked," despite reasonable efforts being made to prevent this from occurring.
e. Providers will not be able to perform a true physical examination, check vital signs or take other actions, that may be part of the standard of care, for the prescription of certain medications or when assessing patients with certain presentations or conditions. If my provider recommends that I purchase a blood pressure cuff and record data, see my primary care physician for vitals or take other actions to mitigate the risk of an adverse outcome because of this, it is my responsibility to do so, and I acknowledge that not doing so, may result in physical harm to me or an adverse outcome.

7. I agree that information exchanged during my telehealth visit will be maintained by doctors, nurse practitioners, therapists, administrators, and other providers involved in my care.
8. I understand that medical information, is governed by federal and state laws that apply to telehealth.
9. I understand that Skype, FaceTime, Doxy or similar services may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed. If I have questions pertaining to the platform that my provider is using, it is my responsibility to discuss with my provider and/or BOSC Mental Health staff members before any telehealth appointments.
10. I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications with others.
11. The healthcare provider is not responsible for breaches in confidentiality caused by an independent or third party or by me.
12. I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may result in the termination of my telehealth visit.
13. I understand that I have the responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.
14. I understand that electronic communication cannot be used for emergencies or time-sensitive matters.
15. I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As a patient, I agree to accept responsibility for following my healthcare provider's recommendations- including further diagnostic testing, such as lab testing or an in-office visit.
16. I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, mental health information and addiction treatment (alcohol and drug use, abuse and dependence for example).

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17. I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communication.
18. By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.
19. I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.
20. To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.
21. **I understand that electronic communications should never be used for emergency communications or urgent requests. In the case of an emergency, I will call 911. Telecommunications (including email) are never to be used in the case of an emergency. Additionally, text is never an appropriate form of communication with any of our providers, and we are not responsible for responding to any texts.**
22. If during the course of treatment, a patient's provider deems that they do not have the skill-set or resources to safely provide care to a patient virtually or otherwise (for example, if a patient is assessed as being high risk for self-harm or suicide) the provider will discuss this directly with the patient, provide resources on finding local mental health professionals (for example, providers whom the patient can see for regular face-to-face appointments, with admitting privileges at local psychiatric hospitals and 24-hour emergency coverage), and the patient will be required to transition to a new provider within 90 days; it's important to our practice that we are honest with our patients, and if we do not feel that we are not only a good fit medically, but a SAFE fit, a transition of care will be required. It is the patient's responsibility to make an appointment with another provider and to follow through with this transition of care. Our providers will provide medical records and/or a summary of care to your new provider, with a signed release of information upon your request.
23. If a patient is being seen for addiction, an initial face-to-face visit may be required, and patients will be required to have random drug screens performed within 72 hours of a provider's request, throughout care. If a patient is abusing alcohol or benzodiazepines (Xanax, Valium, Klonopin, Ativan) the provider may require continued face-to-face appointments, for safety purposes, at their discretion. Additionally, your insurance company may not reimburse for telehealth visits. You may or may not be referred to a regular face-to-face provider depending on your unique circumstances.

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I certify that I have read and understand this agreement and that all my questions have been answered to my satisfaction.

For electronic communication between all providers and staff members at BOSC Mental health and:

_____ _____

Print Patient or Legal Representative's Name — Relationship to Patient

Typing Your Name Here Constitutes Legal Signature

_____ _____

Signature – Patient or Legal Representative — Date

Typing Your Name Here Constitutes Legal Signature