Informed Consent - Behavioral Medicine Institute

Welcome! The Behavioral Medicine Institute, P.C. (BMI) is pleased to welcome you or your family member as a patient. Your health is our primary concern, and our goal is to provide you with the best care possible. Please review the following information and speak with our staff and/or your clinician about any questions you have concerning this document.

Pre-Authorizations For Our Services: Our staff will attempt to verify your eligibility and to obtain any necessary pre-authorizations for your evaluation and/or treatment here **if** you provide us the necessary information, but ultimately it is your responsibility to insure that you have coverage for and/or required referral and/or required pre-authorization for our services. **We strongly advise you to call your insurance company to verify your coverage before your appointment.** Failure to obtain pre-authorization or necessary referral may result in your insurance declining coverage for your visit and you being held financially responsible for the visit.

Appointments: Our clinicians see patients by appointment only. Except in emergencies, 24 hours' notice is required for cancelled appointments. **If you cancel your appointment with less than 24 hours' notice, you will be charged the full fee, not just your co-pay, for the missed appointment**. Note that your insurance will not pay for missed appointment charges. If you cancel three times with less than 24 hours' notice, services may be terminated. Reminder calls are a courtesy only; absence of a reminder does not relieve you of your responsibility to keep your appointment.

Fees, Payment, & Insurance: Our office staff will file your insurance claim for you, as a courtesy to you. However, ultimately, it is your responsibility to know your insurance policy's requirements, benefits, limits, and status. Your insurance deductible, co-pay, and/or co-insurance payment is due at the time of service, unless arrangements have been made in advance with our office. **If you wish to utilize your EAP benefit, you must inform the office staff in advance of your appointment** and your clinician at the beginning of every eligible visit.

Phone Calls & Emergencies: If you need to reach your clinician during office hours, please leave him or her a message and your call will be returned as promptly as possible (typically the same day). If you have a life-threatening emergency, call 911. For non-life-threatening emergencies, call BMI's main number, (865) 264-2400, and select the option to contact your clinician. Follow the instructions provided in your clinician's voicemail message. If your call is not returned within a reasonable amount of time, call back and repeat your message--be sure to leave the correct telephone number, including area code**. Note that there is a charge for telephone consultations after normal business hours and on weekends, and that your insurance will not cover telephone consultation charges.** Please do not call the emergency number for scheduling concerns or non-emergency matters. If you need to cancel or change an appointment, please dial our regular number, (865) 264-2400, and follow the voicemail prompts.

Research: BMI may occasionally use and disclose your information in an **anonymous** fashion for research purposes when the research has been approved by an institutional review board. This research is designed to study the effectiveness of our assessments and treatments and is conducted to make us an always improving practice.

Electronic Medical Record & Patient Portal: BMI utilizes an electronic medical record (EMR) which is shared by all providers in the practice. If you see multiple providers in the practice, they will all have shared access to your clinical record. The EMR (and Tennessee law) also allows us access to all the prescriptions you have had filled in the past year. **We ask all patients to set up an online Patient Portal**, which allows us to communicate with you in a secure, HIPAA-compliant manner, and allows you to check your appointments, update important information, and give us feedback on your treatment. Please call or speak to the front office staff to initiate this process.

Agreement: By my signature, I acknowledge that I have read, understand, and agree to all the policies on this page. I agree to evaluation and/or treatment at The Behavioral Medicine Institute, P.C. (BMI). I authorize BMI to furnish information as required to my insurance carrier concerning my evaluation and/or treatment. I assign to BMI all payments for services provided to me and/or my dependents. I authorize my clinician at BMI to have unrestricted two-way communication with other clinicians at BMI and to share my health information—including mental health, alcohol and drug, and/or HIV status—with my referring health care provider and/or my primary care practitioner if I have listed them on my Patient Registration/Update Form. I authorize BMI to leave text messages or voicemail messages, including pre-recorded messages, at any of the telephone numbers, including wireless phones, which I have provided on my Patient Registration/Update Form. I authorize BMI to send emails to any email address which I have provided to them regarding routine scheduling matters and my account balance. I authorize BMI to contact the emergency contact I have listed on my Patient Registration/Update Form in the event of an emergency. I understand that it is my responsibility to insure that I have coverage for and/or required referral and/or required pre-authorization for BMI services. I agree to be responsible for all charges incurred as a result of my evaluation and/or treatment at BMI, regardless of insurance coverage or pending litigation. I further understand that I may be subject to interest charges and/or to being turned over to a credit bureau and/or collections agency if not paid within 90 days of the date of service, and that all fees charged by the collection agency to BMI will be added to my account balance at BMI. I also understand that I will be charged for cancellations made with less than 24 hours' notice or in the event I fail to keep my scheduled appointment.

Patient Rights and Responsibilities

Your insurance company wishes us to inform you of the following:

Patients have the right to:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other Patient information kept confidential. Only where permitted by law may records be released without the Patient's permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive information in a language they can understand.
- Receive a clear explanation of their condition and treatment options.
- Receive information about their insurance company, its providers, programs, services and role in the treatment process.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about their care made on the basis of treatment needs.

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information that they need. This is so providers can deliver quality care and appropriate services.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the Patient and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Patients should call their provider(s) as soon they know they need to cancel an appointment.
- Let their provider know when the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

Patient Notification of Privacy Rights

This form is federally-required and explains your privacy rights under HIPAA.

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

I. Preamble. Tennessee licensing laws provide strong privileged communication protections for conversations between your clinician and you in the context of your established professional relationship with him/her. It should be noted that privileged communication is not the same as documentation. Documentation refers to the mental health written records that are kept about you and your care; such documentation is required by law, professional standards, and other review procedures.

HIPAA very clearly *separates* your mental health record into two parts: (1) sensitive, personal information ("psychotherapy notes")(see section II, below) and declares this information off limits to insurance companies and others, and (2) less sensitive information (the so-called "designated medical record") that includes factual information such as the dates of sessions, notes of a general nature about whether progress is being made, and other, less delicate information about your treatment at our office. Further details about this are contained in the present document, below.

HIPAA establishes privacy protections for your personal health information. (HIPAA has coined a new phrase: Protected Health Information," or PHI). PHI has three (3) components: *treatment, payment, and health care operations*. *Treatment* refers to activities in which your clinician provides, coordinates, or manages your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition. *Payment* is the obtaining of reimbursement for your mental health care. An example that is relevant for your treatment at the Behavioral Medicine Institute is the filing of insurance on your behalf. *Health care operations* refers to those

activities that are related to the performance of our practice, such as quality assurance and utilization review (UR). When UR occurs, your insurance company reviews the documentation of psychotherapy (your clinical record) in order to determine medical necessity.

The *use* of your protected health information refers to activities our office conducts for filing your claims, scheduling appointments, keeping records and other tasks *within* our office related to your care. *Disclosures* refers to activities you authorize which occur *outside* our office such as the sending of your protected health information to other parties (for example, your primary care physician, your outside psychiatrist).

II. Uses and Disclosures of Protected Health Information Requiring Authorization. The state of Tennessee requires the patient's authorization and consent for treatment, payment, and healthcare operations. HIPAA does nothing to change this requirement by law in Tennessee. Your clinician may disclose PHI for the purposes of treatment, payment, and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing your clinician to provide treatment and to conduct the administrative steps associated with your care (for example, file insurance for you) and to collaborate with your other providers regarding your care.

There is a third, special authorization provision that is relevant to the privacy of your records: your clinician's psychotherapy notes. Please note that BMI clinicians typically just keep "progress notes" and **rarely** utilize psychotherapy notes. But in recognition of the importance of the confidentiality of conversations between the clinician and the patient in treatment settings, HIPAA permits keeping "psychotherapy notes" separate from the overall "designated medical record." "Psychotherapy notes" cannot be secured by insurance companies nor can the insurance company insist upon their release for payment of services. "Psychotherapy notes" are *your clinician's* notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and that are separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at our office: assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

Certain payers of care, such as Medicare and Workers Compensation, may require the release of both your progress notes and your clinician's psychotherapy notes in order to pay for your care. If your clinician is asked to submit his/her psychotherapy notes in addition to his/her progress note for reimbursement for services rendered, you will be asked sign an additional authorization directing your clinician to release his/her psychotherapy notes. Most of the time we will be able to limit reviews of your protected health information to only your "designated record set" which includes the following: all identifying paperwork you completed when you first started your care at this office; all billing information; a summary of your first appointment; your mental status examination; your individualized, comprehensive treatment plan; your discharge summary; progress notes; reviews of your care by managed care companies; results of psychological testing; and any authorization letters or summaries of care you have authorized your clinician to release on your behalf. Please note that the actual test questions or raw data of psychological tests which are protected by copyright laws and the questions or raw data of psychological tests which are protected by copyright laws and the need to protect patients from unintended, potentially harmful use are not part of your "designated mental health record".

You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already completed in which you previously instructed your clinician to complete, or if the authorization was obtained as a condition for obtaining insurance and Tennessee law provides the insurer the right to contest the claim under the policy.

III. Business Associates Disclosures. HIPAA requires that we train and monitor the conduct of those performing ancillary administrative services for our practice and refers to these people as "Business Associates." In our practice, "business associates" does *not* include our secretaries, who are our employees. Yet, we do train and monitor their duties, in a manner consistent with HIPAA practices, in order to protect your privacy. Being a small psychotherapy practice, we have very few business associates; these associates include our billing office, our accountant and bookkeeper, and our cleaning crew. Their specific activities do bring them into some measure of contact with your protected health information. In compliance with HIPAA, we have signed a formal contract with each of these business associates which very clearly spells out to them the importance of protecting your mental health information as an absolute condition for employment. We train them in our privacy practices, monitor their compliance, and correct any errors, if they should occur.

IV. Uses and Disclosures Not Requiring Consent nor Authorization. By law, protected health information *may* be released without your consent or authorization under any of the following circumstances:

- Child abuse
- Suspected sexual abuse of a child
- Adult and Domestic Abuse
- Health Oversight Activities (e.g., licensing board for Psychology in Tennessee)
- Judicial or administrative proceedings (e.g., if you are ordered here by a court of law for a disability evaluation)
- Serious Threat to Health or Safety (e.g., our "Duty to Warn" law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s))

We never release any information for marketing purposes.

V. Patient's Rights and Our Duties. You have a right to the following: *The right to request restrictions* on certain uses and disclosures of your protected health information which your clinician may or may not agree to but if he/she does, such restrictions shall apply unless our agreement is changed in writing; *the right to receive confidential communications by alternative means and at alternative locations.* For example, you may not want your bills sent to your home address so we will send them to another location of your choosing; t*he right to inspect and copy* your protected health information in our designated mental health record set and any billing records for as long as protected health information is maintained in the record; *the right to amend* material in your protected health information, although your clinician may deny an improper request and/or respond to any amendment(s) you make to your record of care; *the right to an accounting of non-authorized disclosures* of your protected health information; t*he right to a paper copy* of notices/information from your clinician, even if you have previously requested electronic transmission of notices/information; *the right to revoke your authorization* of your protected health information except to the extent that action has already been taken.
For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask your clinician for further assistance on these matters. We are required by law to maintain the privacy of your protected health information and to provide you with a notice of your privacy rights and our duties regarding your PHI. Behavioral Medicine Institute reserves the right to change its privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of our policies when you come for a future appointment(s). Your clinician's duties on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and our privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of our internal policies for executing privacy practices, please let your clinician know and he/she will get you a copy of these documents that are kept on file for auditing purposes.

VI. Complaints. Dr. C. Keith Hulse is the appointed "Privacy Officer" for The Behavioral Medicine Institute, P.C. per HIPAA regulations. If you have any concerns that this office may have somehow compromised your privacy rights, please do not hesitate to speak to Dr. Hulse immediately about this matter. You will always find him willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written compliant to the Secretary of the U.S. Department of Health and Human Services.

VII. Effective Date. This notice shall go into effect March 7, 2003 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

2020 Informed Consent Signature Page - Behavioral Medicine Institute

Patient Name: _____Date of Birth: _____

I have read and understand the Informed Consent document provided to me by Behavioral Medicine Institute, P.C. (BMI) and I understand and agree to all the terms and conditions within, including but not limited to the assignment of insurance benefits, pre-authorization/referral/EAP requirements, cancellation/appointment policies, and how the contact information I provide will be used. I further agree that an electronic copy of my signature(s) on this page shall have the same legal status as my original signature.

Signature: **Date:**

I have read and understand BMI's Patient Rights and Responsibilities document and I understand and agree to all terms and conditions contained within.

Signature: **Date:**

I have read and understand BMI's Patient Notification of Privacy Rights document and I understand and agree to all terms and conditions contained within.

Signature: **Date:**

I understand that, consistent with HIPAA and Tennessee Law, BMI has access to information regarding all prescriptions filled by me in the past 12 months, as provided by the Dr. First database and the Tennessee Controlled Substances Monitoring Database (CSMD).

Signature: **Date:**

I give BMI permission to share my health information—including initial evaluation and progress notes and specifically regarding my mental health, alcohol and drug, and/or HIV status—with my referring health care provider and/or my primary care practitioner if I have listed them on my BMI Patient Registration/Update Form. I **also** authorize BMI to disclose my health information to the following individuals: (Please list all parties we may discuss this information with [spouse, other family members, etc.] below, **including yourself if the patient is a minor).**

Signature: **Date:**

Person's Full Name	Relationship To You	Their Primary Phone number

2020 BMI Patient Registration/Update Form

DO NOT list any information which you DO NOT want us to use to contact you or your healthcare providers	
Patient's Full Name:	**Co-Pay (as listed on your insurance card):**
Preferred Name (if different):	**Your Primary Insurance:**
Address 1:	**Who is "The Insured?" (the Guarantor):** ____Me ____Spouse ____Parent ____Other:
Address 2:	**Secondary Phone:** **Type of Phone:**
City	**Preferred Email:**
State: **Zip:**	**Emergency Contact Name:**
Main Phone: **Type of Phone:**	**Emergency Contact Phone:**
Birthdate: **SSN:**	**Their Relationship To You:**
Marital Status: **Sex:**	**Appointment Reminder Preference:** ____Email ____ Voicemail ____Text Message ____None

If you are NOT "The Insured" (the Guarantor), we need the following information on the persons who are:	
Guarantor 1 Name:	**Guarantor 2 Name:**
Address:	**Address:**
City:	**City:**
State: **Zip:** **Phone:**	**State:** **Zip:** **Phone:**
Social Security #: **DOB:**	**Social Security #:** **DOB:**

If you wish us to coordinate care, please provide the following optional information:	
Referring Provider:	**Primary Care Provider:**
Their Address:	**Their Address:**
Phone: **Fax:**	**Phone:** **Fax:**

I verify that all information above is accurate to the best of my knowledge. I authorize BMI to use any and all information which I have provided above as means to contact me, my listed healthcare providers, and others, as outlined in BMI's Informed Consent Document and Signature Page.

Signature: **Date:**

(Patient Signature, or Legal Guardian Signature if Patient is a Minor or Legal Charge)

Behavioral Medicine Institute, P.C.

INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Patient Name: _____

Signature of Patient/Patient's Legal Representative: _____

Date: _____

Psychologist Name: _____

Signature:_____

BEHAVIORAL MEDICINE INSTITUTE, P.C.

6231 HIGHLAND PLACE WAY, SUITE 101, KNOXVILLE, TN 37919
1128 E. WEISGARBER ROAD, SUITE 210, KNOXVILLE, TN 37909
EMAIL: INFO@BMIPC.COM WEB: WWW.BMIPC.COM
T: 865-264-2400 F: 865-588-6406

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

I hereby authorize _____ of Behavioral Medicine Institute, p.c. to
(BMI Provider)

☐ Request health information from: ☐ Discuss health information with: ☐ Send Health Information to:

Name of Person, Provider, or Facility _____
Address _____
Phone (_____) _____ Fax (_____) _____

For the purpose of: ☐ Patient request ☐ Treatment planning ☐ Other

To include: ☐ Entire Record ☐ Portion of Record _____ ☐ Other _____
(Specify) (Specify)

All information regarding care received by patient between the dates of _____ & _____
(Starting Date) (Ending Date)

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated. the information. if such information exists. cannot be released or discussed.

Initial	Date	
_____	_____	Alcohol and/or Drug use/abuse treatment
_____	_____	Mental Health Treatment
_____	_____	HIV Status or Treatment

- I understand that I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, to the attention of the Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment in which case you may refuse to provide that research-related treatment).

_____ _____ _____
Printed Name of Patient or Authorized Representative Signature of Patient or Authorized Representative Date

_____ _____ _____
Relationship of the Authorizing Representative Signature of Witness Date