Future Forward Wellness
3610 N 44th St / Ste 210 / Phoenix, AZ 85018
tel: (602)441-4921 / fax: (866)993-0559
www.futureforwardwellness.com
hello@futureforwardwellness.com

CONSENT TO TREATMENT AND CLINIC POLICIES

By signing this document, I acknowledge and consent to the policies and conditions of treatment. I understand that all new patients are provided a copy of these policies and that agreement to follow them as described is required to establish and maintain treatment at Future Forward Wellness (FFW).

- **HIPAA PRIVACY PRACTICES:** I have been provided a copy of Future Forward Wellness's Notice of HIPAA Privacy Practices, have had an opportunity to discuss them and understand them to my satisfaction. I consent to the use and disclosure of my or my child's Protected Health Information (PHI) by Future Forward Wellness and its Business Associates for the purpose of diagnosing, providing treatment, obtaining payment, and conducting operations. I understand that my treatment may be conditional upon this consent, although I do have a right to request restrictions as to how PHI is used.

- **RELATIONSHIP WITH HEAD TO TOE THERAPY, INC:** I understand that Future Forward Wellness and its providers have a close working relationship with Head to Toe Therapy, Inc (H2T). I understand that my PHI is fully protected by Business Associates Agreements between the two companies, and allow use of PHI by H2T as needed for my treatment, billing, and coordination of care as allowed under HIPAA. Some specialty services may be provided at FFW by H2T clinicians. FFW in many cases works with H2T for billing purposes, and I understand that receipts and correspondence with insurers may list H2T rather than FFW. Credit card bills may also reflect H2T

- **CONSENT FOR MINORS:** I understand that, for minors entering treatment, decisions about psychiatric, other behavioral health and medical care must be made by the child's legal guardian(s), who must have an opportunity to be fully informed of the evaluation process and treatment recommendations and options. In the situation of a parental separation or divorce (except in the case of one parent having sole physical and legal custody), both parents must consent, in writing, to the psychiatric evaluation, and both parents are invited and encouraged to participate in the process of evaluation and treatment. If one parent retains sole physical and legal custody, this parent must provide legal documentation of this in order for the psychiatric evaluation to occur as scheduled. Both parents, regardless of custody, have a legal right to medical records.

- **CONSENT TO OBTAIN MEDICATION HISTORY:** I agree that FFW may request and use my prescription medication history from other providers, state databanks, pharmacies, and/or third-party payers for treatment purposes.

- **NONSECURE COMMUNICATION:** I understand that conventional voicemail, email, text/SMS, and videochat (eg Skype) may not be fully secure, and that I have a right to use either secure or nonsecure methods of communication. I agree to inform Future Forward Wellness if I DO NOT allow nonsecure communications. I have been informed of the risks, including but not limited to my confidentiality in

treatment, of transmitting my protected health information by unsecured means. I understand that my chosen methods of communication do not affect whether I can receive treatment. I also understand that I may terminate this authorization at any time. I understand that if I initiate such communication (eg by texting or email) that consent for reciprocal communication by FFW is implied.

- **LIMITATIONS ON INSURANCE COVERAGE:** I understand that FFW will make good-faith attempts to verify my insurance coverage as a courtesy when possible prior to my first appointment and any coverage issues will be communicated to me; however, I understand that this is not a guarantee of coverage and any charges not paid by the insurance company may be my responsibility including deductibles, copays disallowed charges, and adjudicated amounts. If prior authorization for services is needed, I understand that it is my responsibility to notify FFW in advance and that charges denied due to lack of authorization may be my responsibility.

- **PATIENT/GUARDIAN RESPONSIBILITY FOR PAYMENTS:** I agree to pay any charges due including co-pays, deductibles, and outstanding balances prior to each visit, and understand that I may not be scheduled for follow-up appointments while there is a balance due; if I am seen emergently while in arrears, I understand that I may be given a 30-day termination notice at the discretion of the provider and FFW.

- **CONSENT TO MAINTAIN AND CHARGE CREDIT/BANK ACCOUNT ON FILE:** I hereby authorize Future Forward Wellness or sister company Head to Toe Therapy, Inc to charge my credit card or debit my banking account for balances that are over 30 days due, to charge regular office visits at the time of service unless I pay by other means, and to charge for missed appointments according to standard policy as discussed below. I agree that my credit card or banking information will be kept securely on-file, and I further agree that, in the event my credit card becomes invalid, I will provide a new valid credit card upon request to be charged for the payment of any outstanding balances owed.

- **SELF-PAY AND OUT-OF-NETWORK BENEFITS:** I understand that I have a right to self-pay for my care and forgo insurance coverage. I agree NOT to file out-of-network claims to insurers with whom FFW is an in-network contracted provider. FFW can provide a 'superbill' to be filed by patients with out-of-network insurers. I agree to disclose to FFW if I have AHCCCS/Medicaid or Medicare.

- **NONCOVERED SERVICES:** I understand that some specialty, intensive, comprehensive, alternative, experimental, and other services may not be covered by insurance and are offered on a fee-for-service basis due prior to treatment. This will be made clear by FFW prior to provision of service. I understand that FFW will provide a standard receipt on request but not a superbill, and I will not seek insurance reimbursement unless explicitly allowed by my provider. I agree to disclose to FFW if I have AHCCCS/Medicaid or Medicare.

- **CHARGES FOR MISSED APPOINTMENTS:** If I do not show for an appointment with 24-business-hours notice (voicemails left on the main FFW number are acceptable notice), I understand that I will be charged a no-show fee of $150 for new patient intakes or $75 for established patient follow-ups. Arriving 10 minutes or more late to an appointment may be considered a no-show.

- **TERMINATION FOR REPEATED MISSED APPOINTMENTS:** I understand that if I no-show or cancel a second appointment with less that 24-business-hours notice I may be sent a letter terminating my care

with 30 days notice, during which I may be seen for refills or urgent appointments at my provider's discretion. If the missed appointments are consecutive I waive my right to a notice period.

- **COOPERATION WITH ONLINE PATIENT PORTAL ASSIGNMENTS:** I will establish a secure patient portal account through the Valant Electronic Medical Record used by FFW. I am responsible for completing assignments indicated by my provider prior to each visit, and may not be seen and charged a no-show fee if I do not. I understand that, if I arrive 45 minutes prior to the session, it may be possible to complete the assignments at the clinic provided that a computer is available.

- **DISABILITY, FMLA, AND OTHER FORMS:** I understand that Future Forward Wellness and its providers are not obligated to fill out disability and other such paperwork. No disability forms will be filled out for patients in treatment less than 90 days. When forms are filled out at the provider's discretion, there will be a charge of $20 per page.

- **COURT AND LEGAL SERVICES:** I understand that FFW and its providers do not work with forensic matters or court-ordered treatment. If subpoenaed to testify or appear in court all related costs and time spent on the matter will be billed to the responsible attorney.

- **CONTROLLED SUBSTANCES:** I understand that Future Forward Wellness and its providers are NOT obligated to dispense medications that they see as potentially harmful, particularly controlled substances such as stimulants (Adderall, Ritalin), benzodiazepines (Xanax, Valium, Klonopin), or narcotic pain-killers. Generally, such prescriptions are not dispensed at the first several meetings, even if they were started by an outside provider; referrals to appropriate detox facilities will be made if indicated. Urine toxicology may be required as a condition of receiving prescriptions for certain medications.

- **PROHIBITED ITEMS:** I understand that no firearms, illicit substances, or alcohol may be brought onto the premises, and that violations may be grounds for immediate termination and prosecution.

- **LABORATORY TESTING:** I understand that certain medical conditions can cause psychiatric symptoms, and some psychiatric conditions and medications require laboratory monitoring for safety. Complying with provider orders for laboratory tests (either going to a lab or providing recent results ordered by another provider) is a condition of treatment, and treatment may be terminated for repeated non-adherence.

- **REFILLS:** It is the client's responsibility to make refill requests 5 days before running out of medications. Urgent refills are only filled at the discretion of the provider.

- **SUPERVISORY RELATIONSHIPS**: I understand that in some cases unlicensed providers or therapists may provide treatment under a supervisory relationship with a licensed provider, and that FFW will inform patients of such circumstances prior to treatment by an unlicensed practitioner, trainee, etc. I understand that I have a right to refuse treatment, but that alternative licensed providers may not be available.

- **TERMINATION:** I understand that I may terminate treatment at any time and request that their medical records be sent to another provider. Future Forward Wellness may terminate treatment for reasons including but not limited to: it is determined that inadequate expertise or facilities are available to treat

the condition; a higher level of care is required (eg intensive outpatient, residential, or hospital-based treatment) for safety or acuity; the agreed upon treatment plan is not adhered to; withholding or misrepresentation of important information; misuse of prescribed medication; multiple no-shows or cancellations; repeated failure to pay for service; or threatening, obscene, belligerent, or otherwise disruptive behavior. Written notice notice of termination with a 30-day period with referrals to other community providers is generally offered except in cases of gross non-adherence or inappropriate behavior that do not allow for any ongoing productive treatment relationship.

- **EMERGENCIES:** If you are experiencing a true emergency, please dial 911. Messages left on our voicemail will be answered within one business day. Matters requiring a call back may be left with our answering/paging service as directed by the voicemail menu to be triaged by a staff member; only truly urgent calls will be forwarded to the physician on call. Help can also be sought from:

  Psychiatric Urgent Care Faciities:
  Connections Arizona (UPC): 502-416-7600
  Recovery Innovations of Arizona: 602-650-1212
  Banner Psychiatric Center: 480-448-7600

  Crisis Lines:
  National Suicide Crisis Hotline: 800-273-TALK
  Maricopa County Crisis Response Network: 800-631-1314 or 602-222-9444
  Empact Crisis: 480-784-1500
  Graham, Greenlee, Santa Cruz, Cochise, Pinal, Gila, La Paz, and Yuma County Crisis Line: 866-495-6735
  Apache, Coconino, Mojava, Navajo, and Yavapai County Crisis Line: 877-756-4090
  Gila River and Ak-Chin Indian Communities: 800-259-3444

I have received, reviewed, and agree to the above office policies including the HIPAA Notice of Privacy Practices, and consent to consultation and/or ongoing treatment of myself or my child. I have been offered a copy of this document.

_____ _____
Signature of patient or guardian / legal representative Date

_____ _____
Printed name of patient or personal representative Relationship to patient

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Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

I hereby authorize: Name: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

to bilaterally exchange my (or my child's) protected health information as described below with:

Future Forward Wellness and Head to Toe Therapy Inc / 3610 N 44th St / Ste 210 / Phoenix, AZ 85018/ Tel: 602-441-4921 / Fax: 866-993-0559/ hello@futureforwardwellness.com

This authorization for release of information covers the period of healthcare from:
A. □ all past, present, and future periods. ****OR – CHECK ONLY ONE** B.** □ _____ to _____.

I authorize release of the following records:
A. □ my (or my child's complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse), including consent forms, insurance information, demographics, etc
****OR – CHECK ONLY ONE****
B. □ I authorize the release of my complete health record with the exception of the following information:
□ Mental health records □ Communicable diseases (including HIV and AIDS) □ Alcohol/drug abuse treatment
□ Other (please specify): _____
**This medical information may be used by Future Forward Wellness for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
**This authorization shall be in force and effect for ONE YEAR (by default if no other date is indicated) or until _____ (date or event), whichever is shorter, at which time this authorization expires.
**I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
** I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
** I understand that information used or disclosed pursuant to this authorization may by disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of patient or personal representative Date

_____ _____
Printed name of patient or personal representative Relationship to patient

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Consent for nonsecure electronic communications

I understand that I have a right to secure (eg encrypted) transmission of my (or my child's) protected health information (including the fact that I am a patient of this practice, information related to the scheduling of meetings or other appointments, information related to billing and payment, and clinical information arising in the course of treatment.

I understand that conventional voicemail, email, text/SMS, and videochat (eg Skype) may not be fully secure. I authorize Future Forward Wellness via these means unless indicated below. I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time. I understand that if I initiate such communication (eg by texting or email) that consent for reciprocal communication by FFW is implied.

Furthermore, I understand that Future Forward Wellness makes available the following means of communication that are designed to be secure, and I still choose to authorize to the above-named non-secure means:

- *Encrypted email (although I understand that even encrypted email is vulnerable to privacy violations, the that it is not a replacement for in-office assessment and treatment, and that it becomes part of medical record)*
- *Patient web portal*
- *Secure video conferencing (such as Usee)*

I ***DO NOT*** consent to communication by:

O Unsecured email.

O SMS text message (i.e. traditional text messaging) or other type of "text message."

O Unsecured video chat (such as Skype or Facetime).

O Voicemail on my cell phone

O Voicemail on my work phone

O Voicemail on my home phone

Signature:_____ Date:_____

Print Name: _____

Relationship to Patient:_____

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Credit card / direct debit authorization

I hereby authorize Future Forward Wellness or sister company Head to Toe Therapy, Inc to charge my credit card or debit my banking account for balances that are over 30 days due, to charge regular office visits at the time of service unless I pay by other means, and to charge for missed appointments according to standard policy (48 business hours advance notice of cancellations). I agree that my credit card or banking information will be kept securely on-file, and I further agree that, in the event my credit card becomes invalid, I will provide a new valid credit card upon request to be charged for the payment of any outstanding balances owed.

Signature:_____

Print Name: _____

Relationship to Patient:_____

Date:_____