Rise Up Mental Health Care ~ #7 Rosemar Circle Parkersburg WV, 26104

Phone 304-422-7999 Fax 681-661-0257

NOTICE OF PRIVACY PRACTICES

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

For Treatment, Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations.

Subject to certain limitations in the law, your PHI can be disclosed without your Authorization for the following reasons:

When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety

The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask your provider not to use or disclose certain PHI for treatment, payment, or health care operations purposes requests. The Right to See and Get Copies of Your PHI. You have the right to get an electronic or paper copy of your medical record and other information that is on file. disclosures within 60 days of receiving your request. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. Request may be denied with notification in writing, within 60 days of receiving your request. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Notice Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

EFFECTIVE DATE OF THIS NOTICE. This notice went into effect on September 12, 2022.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature_____

Date_____

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PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS Standard meeting time for psychiatric evaluation is 60 minutes with subsequent medication management 15-30 minutes. All co-pays and private pay balance, are due on the date of service unless otherwise arranged with Rise Up Mental Health Care

All clients with private insurance who have applicable co-pays/deductible payments are required to have a valid credit card on file and will be charged. Failure to pay co-pay or deductible payments will result in ineligibility to schedule further appointments

In the event of lapse of insurance coverage, you will be charged the self-pay rate for the visit.

Payment plans are available. Failure to maintain scheduled payment will result in ineligibility to schedule further appointments.

Informed Consent

I or my legal representative have legal capacity to provide Informed Consent for treatment. I have been informed of the advantages and disadvantages of treatment. I consent and agree to treatment up to and including medication services at Rise Up Mental Health Care, LLC.

Informed Consent for Telehealth and Online Behavioral Health Services

I or my legal representative have legal capacity to provide informed consent for telehealth and online behavioral health services. I have been informed of and understand the advantages and disadvantages, risks, benefits and alternatives of video, audio, texting, email and other online services, including limitations to its use. I consent and agree to receive telehealth and online behavioral health services, if available and appropriate and consent and agree to utilization of email, texting and similar technology-based services.

My participation in the process of telehealth is voluntary. I TAKE FULL RESPONSIBILITY FOR THE SECURITY OF TREATMENT RECORDS ON MY OWN COMPUTER / SMART PHONE AND AT MY OWN PHYSICAL LOCATION, INCLUDING EMAIL AND TEXTS. I understand that I can conduct correspondence by text, regular email or by secure email or through an established Rise Up Mental Health Care Portal; however, Rise Up Mental Health Care and my provider cannot guarantee the confidentiality of these except on the Rise Up Mental Health Care end of the communication chain. Rise Up Mental Health Care and my provider cannot guarantee the confidentiality of texts and regular email under any circumstances. I FURTHER AGREE THAT TECHNOLOGY-BASED SERVICES ARE NOT PROPER TO USE TO ADDRESS SUICIDE OR ANY FORM OF HARM TO MYSELF OR OTHERS. THESE SITUATIONS REQUIRE IMMEDIATE AND APPROPRIATE IN-PERSON HELP. I TAKE PERSONAL RESPONSIBILITY FOR ANY ACTION I MAY TAKE.

Notice of Privacy and Practice Policies

I have received, reviewed and consent to the terms described in the Rise Up Mental Health Care Privacy and Practice Policies.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature_____ Date_____

Guardian_____Date_____

MEDICATION POLICIES

I understand that I must sign a Prescription Monitoring Agreement in order to receive medical services at Rise Up Mental Health Services.

I understand that prescriptions for controlled substances/medications are only issued at the time of appointment and if that appointment is a cancellation or a "no show," I must wait until my next appointment to receive my new prescriptions.

I understand that if I "no show" for an appointment for medication management, I must call in and speak with medical office staff to develop a plan for medication refills.

I understand that prescriptions that are lost or stolen are not replaced under any circumstances.

Signature _____ Date_____