DISCOVERY COUNSELING & CONSULTING

Informed Consent for Psychiatric Services and Treatment

Please select A and/or B and sign below

☐ A: I, the undersigned, do voluntarily consent to psychiatric assessment and treatment for myself

☐ B: I, the undersigned, am the parent/legal guardian of (child's name) _____, a minor child. I do voluntarily consent to his/her psychiatric assessment and treatment and agree to be responsible for all fees for services provided.

- I understand that no guarantees are being made to me as to the results of assessment, evaluation, or treatment.
- I am aware that I am an active participant in this endeavor, and that I share the responsibility for treatment by providing all accurate information about my history, or my child's history.
- I understand that assessment and/or treatment will be kept confidential except for disclosures required by law and when necessary, in connection with my care. I am aware that consultations with associates are at times clinically advisable, and my signature below gives my Psychiatric Mental Health Nurse Practitioner (PMHNP) permission to do that.
- I understand that when my PMHNP is unavailable, another behavioral health provider may be providing coverage. I understand that the person providing coverage may be given access to relevant information to provide the best interim care possible.
- I authorize the release of any information necessary to process any insurance claims. This would include an ongoing release of information to meet managed care review requirements or to help get preauthorization for visits and/or medications.
- I understand that if I arrive more than 10 minutes late for my appointment, I may not be able to be seen that day.
- I am aware that there is no charge for brief telephone calls, however, calls regarding treatment or medication issues lasting more than 5-10 minutes will be pro-rated and billed at the regular hourly rate.
- I am aware that all co-payments/co-insurance are due at the time of service and that all balances for all services provided must be paid prior to scheduling my next appointment.
- If you are a member of a Managed Care Organization a "Members Rights and Responsibilities" document may be available to you.
- I understand that telehealth services are provided through technology, potentially including video conferencing, telephone, text, and email. As such, services may not include direct face-to-face communication with my provider.
- I understand and agree that exchange of information and paperwork may be via electronic means, or via mail or fax. I understand that there are risks to electronic transmission of data, including, but not limited to, possible confidentiality breaches and theft of personal data.
- I understand that it is my responsibility to maintain privacy of information that I receive and to exercise any precautions when I am sending information to Discovery Counseling & Consulting (DCC). This includes but is not limited to ensuring that I can hold telehealth sessions in a private space, using a secure internet connection, using security features such as password protection on devices and email accounts.
- I understand that technology is subject to periodic technical difficulties and service disruptions. I understand that DCC does not guarantee technology will be error free or uninterrupted and any technology provided by DCC is provided as-is without warranty.
- I understand that my PMHNP may determine that telehealth treatment is not the appropriate method of service delivery for me, and if this happens, my PMHNP will discuss this decision with me, and provide me with alternate referrals and resources, as needed. I understand that it is my right to discontinue telehealth services at any time.
- I understand that I will be asked to maintain an active credit card on file for purposes of billing for telehealth sessions and I authorize DCC to charge my card for all fees and services provided.
- The laws and professional standards that apply to in-person services also apply to telehealth

services. I understand that this document does not replace other agreements, such as documentation of informed consent.

Medication Policies:

- I am aware that my PMHNP, or their support staff, will make every effort to return calls within 72 business hours.
- I am aware that I may be required to sign additional contracts should my PMHNP deem it appropriate to prescribe a controlled substance.
- I understand that certain medications may require monitoring parameters to be started/ continued. This may include but is not limited to ongoing lab work, drug screening, blood pressure, and weight.
- I understand that my PMHNP participates in the Prescription Monitoring Program and, by law, may access information about me and/or report information about me, as applicable.
- I agree to inform my PMHNP if I begin, or plan to begin, receiving psychiatric medication management services from another provider as I cannot receive care from more than one provider concurrently.
- I am aware that it is my responsibility to inform my provider of any and all other medications being prescribed or taken over the counter, to include supplements, vitamins, etc. and understand that any other medications of a psychiatric nature must be approved by my practitioner. Controlled medications may NOT be prescribed by any other prescriber unless approved by my DCC PMHNP and failure to adhere may result in immediate termination of services.
- I understand that it may take up to 72 business hours for a refill request to be completed, that it will only be considered once a follow-up appointment within 30 days has been scheduled
- There is no guarantee that my PMHNP will approve a medication refill request between appointments. If approved, a $15 fee will be applied.
- Some Schedule II-IV medications will not be authorized to fill early.
- Controlled substances may require a hard copy prescription and will not be authorized to fill early.
- Unless approved by my PMHNP, no changes to medication will be made outside of scheduled appointments.
- I may only request a medication refill once before attending my next appointment.
- I understand that medication changes, refill requests, and questions concerning my medications will not be addressed on evenings or weekends.
- I understand that it is my responsibility to plan ahead and schedule an appointment prior to running out of my medication.
- I understand that if I no-show or late cancel for my appointment and require medications, no changes will be made, and medications will be refilled for 7 days only until I have an appointment scheduled.
- I understand that if I have not attended an appointment for more than 6 months my case will be considered closed, my medications will not be refilled, and I will need to schedule a new patient intake appointment.
- If I am terminated for any reason from DCC, a 30-day supply of most medications will be provided to me at my PMHNP's discretion.

<u>Psychiatric Emergency Policy</u>:

If you are experiencing a psychiatric emergency, a life-threatening emergency, and/or medication side effects causing shortness of breath, heart problems, severe rash, or other life-threatening concerns, please call 911 or go to your nearest emergency room. Medication management is addressed during regular business hours only, when your PMHNP is in the office.

<u>Patient Rights/Discharge</u>:

Any of the below may result in my non-voluntary discharge from treatment:

- Exhibiting physical violence, physical or emotional intimidation, verbal abuse of any kind, including phone calls/messages.
- Bringing weapons into the clinic or engaging in illegal acts of any kind.
- Refusing to comply with clinic rules, refusing to comply with treatment plans/recommendations, or failure to make a payment and/or payment arrangements in a timely manner.
- Repeatedly canceling, late canceling, or no showing for appointments.
- I may choose to terminate treatment at any time of my own accord and a 30-day supply of most medications will be provided.

I have the right to revoke this consent in writing and terminate services at any time.

I have read and understand the information on this sheet. My signature below indicates my informed consent.

_____

Patient Name

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian Date

Relationship to Patient: _____

DISCOVERY COUNSELING & CONSULTING

Stimulant Therapy Agreement & Consent

This document is an agreement between you (Patient) and your psychiatric provider (PMHNP) regarding the use of stimulant medications.

Patient Name: _____ DOB: _____

I understand and agree to the following conditions for the use of stimulant medications if they are prescribed to me. Alternative therapies have been explained and offered, including the possible risks and benefits of other types of treatments that do not involve the use of stimulants.
The purpose, risks, and potential benefits of using these medications have been explained to me by my provider and include the following:

- I understand that the use of stimulant medications may be stopped if the medication does not improve my ability to function, if unacceptable side effects develop, or if I do not follow all parts of this agreement.
- I understand that the main goal of treatment with these medications is to improve my overall quality of life.
- I understand that taking usual doses of these medications may increase my risk for serious cardiovascular events, including heart attack, stroke, or sudden death. I will not drive or operate dangerous machinery until I am sure I can do so safely.
- Some other side effects of these medications include the following: high blood pressure, increased heart rate, changes in vision, inability to sleep, headache, decreased appetite, stomach pain, dry mouth, weight loss, anxiety, and decreased sex drive. I will notify my provider if any of these side effects occur.
- I understand that using these medications to treat my condition may result in dependence on the medication. Abruptly stopping these medications can lead to symptoms of withdrawal, such as irritability, difficulty sleeping, lack of energy, depression, and suicide. I understand that withdrawal is uncomfortable and possibly life-threatening. For my safety, if I stop my medication for any reason, I will do so under the guidance of my provider.
- Females only: Stimulant medications can be harmful to the developing fetus. To the best of my knowledge, I am not currently pregnant, and I agree to pregnancy tests at the request of my PMHNP. I will immediately notify my PMHNP if I plan to become pregnant or suspect that I may be pregnant.

<u>Safety Guidelines of Stimulant Therapy</u>

I understand that I have the following responsibilities:

- I will take medication as prescribed by my provider. I will communicate fully with my PMHNP about the character and intensity of my symptoms, the effect on my daily life, and how well the medicine is helping to relieve them.
- I will not ask for refills earlier than the prescribed interval. Lost or misplaced prescriptions will not be replaced.
- I will keep my medications and prescriptions in a secure, safe place (preventing others access to these medications).
- Timely requests for refills are my responsibility and I understand it may take up to 72 hours for my PMHNP to process my refill request. Changes to my prescription for stimulants will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends. In accordance with state law, prescriptions must be ordered by my provider electronically (e-prescribed) and will not be mailed.
- Renewals are contingent upon keeping scheduled appointments and following prescription directions. I understand that my PMHNP will want to review my stimulant prescription with me at each office visit. Frequency of visits will be at the discretion of my PMHNP.
- If I miss an appointment, I understand that it is my responsibility to reschedule the appointment, and that without one scheduled, my stimulant prescription will not be refilled. Changes to prescriptions cannot be made via telephone request or via patient portal.
- I understand per state law all controlled substances will be monitored via the Virginia Prescription Monitoring Program. Compliance with active treatment plan guidelines as well as disclosure of additional controlled substances will be monitored.

- I understand that I can only fill prescriptions at a pharmacy located in Virginia unless an out-of-state pharmacy is agreed to by the PMHNP.
- I will not request stimulants or controlled substances from other providers, including any Emergency Room (ER) without also notifying my PMHNP at DCC. I understand that other providers should not change the dose of my stimulant and I will notify my provider of any changes to my medications made by another provider and the reason for the change. I will inform other healthcare providers about use of a stimulant and will immediately notify my PMHNP if any other doctors prescribe another controlled substance.
- I will not use street drugs or another person's prescriptions. I will not use alcohol while taking this medication. I will inform my provider of alcohol or drug use, past or present, as well as any history of alcoholism or addiction. My use of this medication will be limited to times when I am not driving or operating machinery and shall be used in a manner consistent with my provider's recommendations.
- I consent to random blood or urine drug screenings to assure that I am taking only prescribed drugs. I understand that all out-of-pocket expenses associated with drug screenings will be my responsibility. I consent to random pill counts. If requested, I will bring my medication, in the original container to DCC at a requested time so that the clinical staff may verify the number of pills.
- I authorize my PMHNP to provide a copy of this agreement to my pharmacy, other health care providers, insurance carrier and any emergency room upon request. I give my permission to allow sharing of my medical history regarding medication use with other health care agencies/facilities including any city, state, or federal law enforcement agency in the investigation of any misuse, sale, or other diversion/inappropriate use of my stimulant.
- I understand that my provider may STOP prescribing my stimulant if:
    - I fail to follow above guidelines (including any specifics my PMHNP has added)
    - If my provider determines, for any other reason, that the stimulant treatment is not advisable.
- I understand that my treatment plan and my compliance to this agreement may be reviewed annually or sooner if so indicated by my provider and that I will participate fully and honestly with such a review and reactivation of the agreement/consent.

I have had an opportunity to read the above agreement and consent or have had it read to me. I have had my questions answered to my satisfaction. I understand and accept the risks, conditions and terms of the proposed treatment as presented. I am signing this form voluntarily and I have full right and power to be bound by this agreement.

☐ I consent to the use of stimulant medication as part of my psychiatric care

Patient Signature: _____

Date: _____

OR

☐ I decline to sign this agreement at this time and thereby acknowledge that I will not be prescribed any stimulant medication by my provider. I reserve the right to request to sign this agreement at any time should my provider and I decide that stimulant medication is the appropriate medical choice for treatment of my symptoms and/or diagnosis.

Patient Signature: _____

Date: _____

DISCOVERY COUNSELING & CONSULTING

Benzodiazepine Therapy Agreement & Consent

This document is an agreement between you (patient) and your psychiatric provider (PMHNP) regarding the use of benzodiazepines. Benzodiazepines are a class of medications that are used to treat a variety of conditions including anxiety, insomnia, detoxification from alcohol and other substances as well as some medical conditions. This document establishes clear guidelines for the safe use of these medications.

Patient Name: _____ DOB: _____

I understand and agree to the following conditions for the use of benzodiazepine medications if they are prescribed to me. Alternative therapies have been explained and offered, including the possible risks and benefits of other types of treatments that do not involve the use of stimulants.
The purpose, risks, and potential benefits of using these medications have been explained to me by my provider.
I am aware that use of benzodiazepines has certain associated risks including, but not limited to:
Drowsiness, dizziness, blurred vision, headache, poor concentration/confusion, impaired coordination, memory loss, grogginess, fatigue, stomach upset, depression, subtle personality changes, dreaming/nightmares, muscle weakness, abuse/death, psychological addiction.

I will not be involved in any activity that may be dangerous to me or someone else while taking this medication. I am aware that benzodiazepine use slows reflexes and reaction time and can increase the risk of motor vehicle accidents. Activities that could be dangerous include, but are not limited to, operating heavy equipment or motor vehicles, working in dangerous environments or being responsible for another individual who is unable to care for themselves.
I am aware that tolerance can occur with the use of benzodiazepines. Tolerance is defined as a need for a higher dose to maintain the same effect. If my PMHNP determines that continued escalation of the dose is not in my best interest, then the benzodiazepine may need to be tapered and discontinued and may necessitate another form of treatment.
I understand that physical dependence is possible within a few weeks of starting benzodiazepine therapy. I am aware that physical dependence means that if my benzodiazepine use is markedly decreased, stopped, or reversed, I could experience a withdrawal syndrome (including but not limited to sweating, increased heart rate and high blood pressure, insomnia, abdominal cramps, tremors, diarrhea, muscle or bone aching, seizures), which may occur in 24-48 hours of last dose. Withdrawal symptoms are usually self-limited but could, in rare cases, be life threatening and may require hospitalization.

I understand that psychological addiction is a possible risk to the use of benzodiazepines. Addiction is recognized when a drug is misused by an individual to obtain mental numbness or euphoria. I understand that if engage in behaviors such as visiting multiple doctors and/or pharmacies in pursuit of a medication, asking for early refills, or paying out of pocket if insurance refuses to cover an early refill that my provider may choose to taper and/or discontinue my medication.

Females only: I understand that while on benzodiazepine therapy I should maintain safe and effective birth control. If I plan to become pregnant or believe that I am pregnant while taking this medication, I will immediately notify my provider. I am aware that benzodiazepines cross the placenta, can cause birth defects, and are therefore classified as class D teratogens. They may lead to the development of dependence and consequent withdrawal symptoms in the fetus. Benzodiazepines are excreted in breast milk and are usually contraindicated in breastfeeding mothers.

All controlled substances must come from the provider whose signature appears below or, during his or her absence, by the covering provider unless specific authorization is obtained for an exception. I will tell my provider about all other medicines and treatments that I am receiving.

Because these drugs have the potential for abuse, strict accountability is necessary when use is prolonged. I understand the importance of compliance to the rules outlined in this agreement to protect my access to controlled substances and to protect my provider's ability to prescribe to me.

Safety Guidelines of Benzodiazepine Therapy

I understand that I have the following responsibilities:

- I will take medication as prescribed by my provider. I will communicate fully with my provider about the character and intensity of my symptoms, the effect on my daily life, and how well the medicine is helping to relieve them.
- I will not ask for refills earlier than the prescribed interval. Lost or misplaced prescriptions will not be replaced.
- I will keep my medications and prescriptions in a secure, safe place (preventing others access to these medications).
- Timely requests for refills are my responsibility and I understand it may take up to 72 hours for my PMHNP to process my refill request. Changes to my prescription for benzodiazepines will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends. In accordance with state law, prescriptions must be ordered by my provider electronically (e-prescribed) and will not be mailed.
- Renewals are contingent upon keeping scheduled appointments and following prescription directions. I understand that my prescribing provider will want to review my benzodiazepine prescription with me at each office visit. Frequency of visits will be at the discretion of my provider.
- If I miss an appointment, I understand that it is my responsibility to reschedule an appointment, and that without one scheduled, my benzodiazepine prescription will not be refilled. Changes to prescriptions cannot be made via telephone request or via patient portal.
- I understand per state law, all controlled substances will be monitored via the Virginia Prescription Monitoring Program. Compliance with active treatment plan guidelines as well as disclosure of additional controlled substances will be monitored.
- I understand that I can only fill prescriptions at a pharmacy located in Virginia unless an out-of-state pharmacy is agreed to by the PMHNP.
- I will not request benzodiazepines or controlled substances from other providers, including any Emergency Room (ER) without also notifying my prescribing provider at DCC. I understand that other providers should not change the dose of my benzodiazepine and I will notify my provider of any changes to my medications made by another provider and the reason for the change. I will inform other healthcare providers about use of a benzodiazepine and inform my PMHNP if any other doctors prescribe another controlled substance.
- I will not use street drugs or another person's prescriptions. I will not use alcohol while taking this medication. I will inform my provider of alcohol or drug use, past or present, as well as any history of alcoholism or addiction. My use of this medication will be limited to times when I am not driving or operating machinery and shall be used in a manner consistent with my provider's recommendations.
- I consent to random blood or urine drug screenings to assure that I am taking only prescribed drugs. I understand that all out-of-pocket expenses associated with drug screenings will be my responsibility. I consent to random pill counts. If requested, I will bring my medication, in the original container DCC at a requested time so that the clinical staff may verify the number of pills.
- I authorize my provider to provide a copy of this agreement to my pharmacy, other health care providers, insurance carrier and any emergency room upon request. I give my permission to allow sharing of my medical history regarding medication use with other health care agencies/facilities including any city, state or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion/inappropriate use of my benzodiazepines.
- I understand that my provider may STOP prescribing my benzodiazepine if:
    - I fail to follow above guidelines (including any specifics my provider has added)

- If my provider determines, for any other reason, that the benzodiazepine treatment is not advisable.

I understand that my treatment plan and my compliance to this agreement may be reviewed annually or sooner if so indicated by my provider and that I will participate fully and honestly with such a review and reactivation of the agreement/consent.

I have had an opportunity to read the above agreement and consent or have had it read to me. I have had my questions answered to my satisfaction. I understand and accept the risks, conditions and terms of the proposed treatment as presented. I am signing this form voluntarily and I have full right and power to be bound by this agreement.

☐ I consent to the use of benzodiazepine medication as part of my psychiatric care

Patient Signature: _____

Date: _____

OR

☐ I decline to sign this agreement at this time and thereby acknowledge that I will not be prescribed any benzodiazepine medication by my provider. I reserve the right to request to sign this agreement at any time should my provider and I decide that this category of medication is the appropriate medical choice for treatment of my symptoms and/or diagnosis.

Patient Signature: _____

Date: _____