Informed Consent to Treatment and Client Rights Form

Amita Jha LLC

Thank you for choosing Amita Jha LLC. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of policies, state and federal laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need.

Your Psychiatrist: Amita Jha MD is a licensed and Board certified psychiatrist engaged in private practice providing mental health services.

Mental Health Services: While it may not be your first choice for change, nor is it ever easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation, behaviors and emotions and move toward resolving your difficulties. By using my knowledge of psychiatry, medicine and psychotherapy, development, change and behavior, I will make observations, offer interpretations, make suggestions, and teach behavior strategies in order to help you move toward resolution or understanding of your situation. It will be important for you to explore your own feelings and thoughts and try new approaches in order for change to occur. You may bring other family members or support to a therapy session if you feel it would be helpful or if this is recommended by your therapist,

Appointments: Appointments are made or changed by calling: 301-468-1001 Monday through Friday between the hours of 8:00 am and 5:00 pm. **To cancel please call at least 48 hours in advance otherwise you may be charged for the session.**

Number of Visits: The number of sessions needed depends on many factors including personal willingness and motivation to change. If you are using managed care benefits, your carrier will determine how many sessions you will be authorized to receive. Please discuss any concerns with me. Therapy sessions are 40-50 minutes in length but may take longer during the initial visit.

Relationship: Our relationship is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that I not have any other type of relationship with you as it may undermine the effectiveness of the therapeutic relationship. My preference is to provide therapy and medication management services only, therefore**, I prefer to not accept cases where I will be required to document disability claims, except for my ongoing cases. In addition, I am not an expert witness. I will not go to court to testify on your behalf or perform evaluations of competency. If you suspect or are planning to require litigation then please notify me in your first appointment so that we can discuss how this may affect your treatment.**

Payment for Services: **By signing this consent for treatment, I, the client seeking services, understand that I am financially responsible for the cost of treatment.** If I am using insurance then I am responsible for obtaining the necessary authorization and confirming coverage. Although the insurance will be billed directly- in some cases insurance will not completely cover the cost of service. In this instance. I understand that I may be billed for any remaining costs. **I am responsible for paying all co-pays and/or co-insurances at the time of service. Co-pays are collected before or after the therapeutic session, and credit cards, cash or checks are accepted as a form of payment.**

Self Pay Fees: $300 for 1st session - $200 for 45 min-l hour - $150 for 20-30 min.

Missed Sessions: I as the client of services. understand that l am responsible to maintain the time that I have schedule with Dr. Jha. ln the event of an emergency. I understand that l am responsible for contacting the office. A 48 hour notice is required for non-emergency cancellations. I will be charged the usual fee for the session for missing or failing to inform the office in time. I also understand that I am making a choice regarding how I spend my time and I do not expect the psychiatrist to maintain an appointment time available only for me, I understand that I may be placed on a waiting list for the next available opening. **In the event that I do not show for my appointment, I understand that the responsibility for resuming treatment is mine.** Two no-shows may result in termination from services.

Although it is the goal of the undersigned Psychiatrist to protect the confidentiality of your records, there may be times when disclosure of your records will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. ln the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records and the Psychiatrists normal hourly rate for the time involved in preparing for and giving testimony. Such payments are to be made at the time or before the time the services are rendered by the Psychiatrist.

Confidentiality: The content of treatment will be kept confidential and a written release will be required to disclose information. By law confidentiality is waived when the Psychiatrist a) must ensure the protection of anyone threatened with violence harmful or dangerous actions. b) actual or suspected child or elder abuse c) when presenting a danger to self or others d) information necessary for supervision or consultation, e) if your arc using insurance as the primary form of payment, your insurance company will require information regarding your case, the diagnosis, course of treatment and prognosis and in some cases the actual case notes, f) if your work for a Federal Agency or are, or will be seeking a security clearance, g) AIDS/HIV infection and possible transmission. h) criminal prosecutions, I) child custody cases. j) a negligence suit brought by the client against the Psychiatrist, or filing a complaint with the licensing board, k) if you are under 18 years of age, please be aware that the law provides your parents the right to examine your treatment records l) information necessary for third party billing services. **While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the HIPPA Notice of Privacy Practices, which is provided to you for more details, and discuss with me any questions or concerns you may have.** By signing this information and consent form, you are giving your consent to the undersigned Psychiatrist to share confidential information with all persons mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care service and payment for those services, and you are also releasing and holding harmless the undersigned Psychiatrist from any departure from your right of confidentiality that may result.

[ ] I HAVE READ THE HIPPA NOTICE OF PRIVACY PRACTICES

Professional Records: The laws and standards of our profession require that I keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem affects your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Records, if you request it in writing, except in

unusual circumstances that involve danger to yourself and/or others or when another individual (other than another health care provider) is referenced and we believe disclosing that information puts the other person at risk of substantial harm. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you initially review them in my presence,

Duty To Warn: In the event that the undersigned Psychiatrist reasonably believes that I am a danger physically or emotionally to myself or another person. I specifically consent for the therapist to warm the person in danger and to Contact the following person as **emergency contact** in addition to medical and law enforcement personnel:

NAME NUMBER

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I will immediately advise the Psychiatrist in the event of any change.

Risks of Therapy: Therapy is the Greek word for change. You may learn things about yourself that you don't like. Personal growth is often preceded by personal or life challenges. Often growth cannot occur until you experience and confront issues that may induce you to feel sadness, anxiety or pain. The success of our work together depends on the quality of the efforts on both our parts and realization that you are responsible for lifestyle choices/changes that may result from therapy. The Psychiatrist offers competent marriage and family therapy, but one risk of couples counseling is the possibility that one partner may exercise their divorce option. The Psychiatrist offers competent addictions counseling but an ongoing risk is the possibility of relapse. Most medications have potential side effiects. These are generally transient with few or no serious consequences. A medication treatment form will bc discussed with you during the treatment session.

Emergencies: Please call 301-468-1002 and it will give instructions for leaving a message on my pager. However I do not provide emergency response services in person after hours. If you are experiencing a psychiatric crisis please contact either 911, or go to your nearest hospital emergency room. Emergencies are urgent issues requiring your immediate action.

Coordination of treatment: In order to provide you with the best possible care I request your permission to speak with your Primary Care Physician and/or Psychiatrist or therapist to inform them that I am providing treatment for you. Any information discussed will conform to all HIPPA and state guidelines for disclosure of information and confidentiality.

[ ] Yes, please contact my PCP/Psychiatrist/Therapist, and I will sign a release form

[ ] No, I do not want you to contact my PCP/Psychiatrist/Therapist

Audio Consent: I understand that Dr. Jha may elect to audio tape my sessions for the purpose of professional development and training purposes.

I/we have read and discussed the Informed Consent to Treatment. I have been given the opportunity to discuss the HIPPA. Notice of Privacy Practices and do hereby give full and voluntary consent for the assessment, treatment or services, and to authorize the undersigned Psychiatrist to provide such care, treatment or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and

that I may stop such care, treatment, or services. I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

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Client/Parent or Guardian Date

As witnessed by:

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Amita Jha MD MPH Date